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ABSTRACT

The papers from three 1979 Congressional hearings examine the abuse and neglect of children, both handicapped and nonhandicapped, in foster homes and institutions. Thirty-two prepared statements are included by representatives of such agencies as the Children's Defense Fund: San Francisco Child Abuse Council: Child Welfare League of America: Parents Anonymous: Department of Health, Education, and Welfare: and state departments of Human Resources. Personal accounts of abuse in institutions or group homes are included. Among many issues addressed are the federal government's role in monitoring programs, conditions of institutions, legal issues, state legislation, and fiscal issues. (CL)

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ABUSE AND NEGLECT OF CHILDREN IN INSTITUTIONS, 1979

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON
CHILD AND HUMAN DEVELOPMENT

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

ON

EXAMINATION OF THE PROBLEMS OF ABUSE AND NEGLECT OF CHILDREN RESIDING IN INSTITUTIONS OR GROUP RESIDENTIAL SETTINGS

JANUARY 4, 1979, SAN FRANCISCO, CALIF.
JANUARY 24, 1979, WASHINGTON, D.C.
MAY 31, 1979, LOS ANGELES, CALIF.

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CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

THURSDAY, JANUARY 4, 1979

SAN FRANCISCO, CALIF.

	Page
Kaplan, Dr. Phyllis, San Francisco; Marie E. White, Sacramento; Jolly K, Parents Anonymous, Torrance; Kathleen Gresher, Berkeley; and Terry Hopkins, Santa Clara, Calif., a panel	3
English, Abigail, National Center for Youth Law, accompanied by Robert Walker, Peter Sandmann, and Peter Bull, a panel	63
Dale, Michael J. Esq., attorney, New York Legal Aid Society; Saul Wasserman, M.D., chairman, Child and Adolescent Committee, Northern California Psychiatric Society; and Margaret Brodkin, executive director, Coleman Children and Youth Services, a panel	96
Roach, Marty, Project Concern; Kathy Baxter, Prevention of Abuse and Neglect of Children in Out-of-Home Care Project, San Francisco Child Abuse Council; Steven Pechter, Children's Advocacy Center; and Patricia Apkaw, Urban Indian Child Resource Center, a panel	122

WEDNESDAY, JANUARY 24, 1979

WASHINGTON, D.C.

Days, Hon. Drew S., III, Assistant Attorney General, accompanied by John E. Huerta, Deputy Assistant Attorney General; Lynn Walker, Chief of Special Litigation Section; Marie Klimesz, attorney, Civil Rights Division; and Karen Siegel, attorney, Office of Legislative Affairs, Department of Justice	156
Martinez, Hon. Arabella, Assistant Secretary for Human Development Services, Department of Health, Education, and Welfare, accompanied by Blandina Cardenas Ramirez, Commissioner for Children, Youth, and Families; and Herschel Saucier, Associate Commissioner, Office of Services for Children and Youth	180
Backman, Jack H., chairman, Committee on Human Resources, Massachusetts Senate, Commonwealth of Massachusetts	212
Wooden, Kenneth, National Coalition for Children's Justice, Princeton, N.J.; Mary Lee Allen, Children's Defense Fund, Washington, D.C.; and Jerome Miller, National Center for Action for Institutions and Alternatives, National Youth Workers Alliance, Washington, D.C.	224
Berman, Sam, executive director, Vista Del Mar Child Care Services, Los Angeles, Calif., on behalf of the Child Welfare League of America, Inc., and Norman Powell, vice president, National Organization of Child Care Workers Associations, Inc., New York, N.Y	289
Barr, William W., Administrator, Social Rehabilitation Administration, Department of Human Resources, District of Columbia, accompanied by Gregory Smiles, Project Director on Institutional Child Abuse, Division of Youth and Family Services, Department of Human Services, State of New Jersey; Donald Kline, Ph. D., Department of Special Education, Utah State University, Logan, Utah; and Larry Aber, special assistant to the director, Child Abuse Unit, Office for Children, Commonwealth of Massachusetts	335

4

THURSDAY, MAY 31, 1979

LOS ANGELES, CALIF.

Page

Steele, Buddy, program supervisor, Glendale Development Center for the Handicapped, Glendale, Calif.; accompanied by Ralph Bak, administrator, Glenridge Center for the Handicapped, Glendale, Calif ---- 401

Dotson, Johnny J., former resident of Mountain Mission School, Grundy, Va., accompanied by Daniel Bloch ---- 413

Curtis, Franklin A., associate director, Human Resources Division, U.S. General Accounting Office, accompanied by Messrs. Benedetto Quattrociocchi, Richard Neuman, Jimmy L. Bowden and Scott Sorensen ---- 429

Comrie, Keith, director, Los Angeles County Department of Public Social Services; accompanied by Sister Mary Elizabeth, executive director, Maryvale Children's Institution; and Phil Manriquez, deputy director, planning and review division, department of social services, California Health and Welfare Agency ---- 470

STATEMENTS

Aber, Lawrence, special assistant to the director, Office for Children, Commonwealth of Massachusetts, Boston, Mass ---- 385

Allen, Mary Lee, representing the Children's Defense Fund, Washington, D.C ---- 254

Backman, Jack H., chairman, Committee on Human Resources, Massachusetts Senate, Commonwealth of Massachusetts ---- 212

  Prepared statement ---- 217

Barr, William W., Administrator, Social Rehabilitation Administration, Department of Human Resources, District of Columbia, accompanied by Gregory Smiles, project director on Institutional Child Abuse, Division of Youth and Family Services, Department of Human Services, State of New Jersey; Donald Kline, Ph. D., Department of Special Education, Utah State University, Logan, Utah; and Larry Aber, special assistant to the director, Child Abuse Unit, Office for Children, Commonwealth of Massachusetts ---- 335

  Prepared statement ---- 351

Baxter, Kathy, Prevention of Abuse and Neglect of Children on Out-of-Home Care Project, San Francisco Child Abuse Council, prepared statement ---- 127

Bayh, Hon. Birch, a U.S. Senator from the State of Indiana ---- 392

Berman, Sam, executive director, Vista Del Mar Child Care Services, Los Angeles, Calif., on behalf of the Child Welfare League of America, Inc., and Norman Powell, vice president, National Organization of Child Care Workers Associations, Inc., New York, N.Y ---- 289

  Prepared statement ---- 293

Brodkin, Margaret, ACSW, LCSW, executive director, Coleman Children and Youth Services, prepared statement ---- 119

Comrie, Keith, director, Los Angeles County Department of Public Social Services; accompanied by Sister Mary Elizabeth, executive director, Maryvale Children's Institution; and Phil Manriquez, deputy director, planning and review division, department of social services, California Health and Welfare Agency ---- 470

  Prepared statement ---- 473

Curtis, Franklin A., Associate Director, Human Resources Division, U.S. General Accounting Office, accompanied by Messrs. Benedetto Quattrociocchi, Richard Neuman, Jimmy L. Bowden, and Scott Sorensen ---- 429

  Prepared statement (with attachments) ---- 433

Dale, Michael J. Esq., attorney, New York Legal Aid Society; Saul Wasserman, M.D., chairman, Child and Adolescent Committee, Northern California Psychiatric Society; and Margaret Brodkin, executive director, Coleman Children and Youth Services, a panel ---- 96

  Prepared statement ---- 99

Days, Hon. Drew S., III, Assistant Attorney General, accompanied by John E. Huerta, Deputy Assistant Attorney General; Lynn Walker, Chief of Special Litigation Section; Marie Klimesz, attorney, Civil Rights Division; and Karen Siegel, attorney, Office of Legislative Affairs, Department of Justice ---- 156

  Prepared statement ---- 165

Page
Dotson, Johnny J., former resident of Mountain Mission School, Grundy, Va., accompanied by Daniel Bloch 413
  Prepared statement 417
English, Abigail, National Center for Youth Law, accompanied by Robert Walker, Peter Sandmann, and Peter Bull, a panel 63
Gresher, Kathleen, prepared statement 47
Hopkins, Terry, parent, prepared statement 39
K, Jolly, founder and consultant, Parents Anonymous, prepared statement 22
Kaplan, Dr. Phyllis, San Francisco; Marie E. White, Sacramento; Jolly K, Parents Anonymous, Torrance; Kathleen Gresher, Berkeley; and Terry Hopkins, Santa Clara, Calif., a panel 3
Kline, Donald F., Ph. D., professor and head, department of special education, Utah State University, Logan, Utah 340
Martinez, Hon. Arabella, Assistant Secretary for Human Development Services, Department of Health, Education, and Welfare, accompanied by Blandina Cardenas Ramirez, Commissioner for Children, Youth, and Families; and Herschel Saucier, Associate Commissioner, Office of Services for Children and Youth 180
  Prepared statement 193
Miller, Jerome G., representing the National Center for Action on Institutions and Alternatives and National Youth Workers Alliance, Washington, D.C, prepared statement 281
National Organization of Child Care Worker Associations, Inc 319
Pechter, Steven, Children's Advocacy Center, prepared statement 142
Powell, Norman, vice president, National Organization of Child Care Workers Associations, Inc., New York, N.Y 307
Roach, Marty, Project Concern; Kathy Baxter, Prevention of Abuse and Neglect of Children in Out-of-Home Care Project, San Francisco Child Abuse Council; Steven Pechter, Children's Advocacy Center; and Patricia Apkaw, Urban Indian Child Resource Center, a panel 122
Smiles, Gregory, project director on institutional child abuse, division of Youth and Family Services, Department of Human Resources, State of New Jersey 366
Society to Terminate Orphanage Placements, Johnny J. Dotson, president, prepared statement 417
Steele, Buddy, program supervisor, Glendale Development Center for the Handicapped, Glendale, Calif.; accompanied by Ralph Bak, administrator, Glenridge Center for the Handicapped, Glendale, Calif 401
Wasserman, Saul, M.D., chairman, Child and Adolescent Committee, Northern California Psychiatric Society, prepared statement 110
White, Marie E., Citizens Advocates of Northern California, prepared statement 55
Wooden, Kenneth, National Coalition for Children's Justice, Princeton, N.J.; Mary Lee Allen, Children's Defense Fund, Washington, D.C.; and Jerome Miller, National Center for Action for Institutions and Alternatives, National Youth Workers Alliance, Washington, D.C 224
  Prepared statement 234
Woods, Marion J., director, California State Department of Social Services, prepared statement 481

ADDITIONAL INFORMATION

Articles, publications, etc.:

  Modest Disposal, a, by Ruskin Goodenoff, founder of the Institute of Mental Myopics 10
  Questions submitted to HEW by Senator Cranston, with responses 210
  Superior Court of the State of California for the County of Yolo Juvenile Court, in Re Yolo County Juvenile Hall 69
  Walnuts Cause Stir, letter to the editor, from the Virginia Mountaineer, a weekly 428

APPENDIX

Additional statements 490
Written responses to questions 524
Articles and resource materials 581

ABUSE AND NEGLECT OF CHILDREN IN INSTITUTIONS, 1979

THURSDAY, JANUARY 4, 1979

U.S. Senate,
Subcommittee on Child and Human Development
of the Committee on Labor and Human Resources,
San Francisco, Calif.

The subcommittee met, pursuant to notice, at 9:30 a.m. in the Ceremonial Courtroom, in the Federal Office Building, Senator Alan Cranston (chairman of the subcommittee), presiding.

Present: Senator Cranston.

Also present: Susanne Martinez, counsel to the subcommittee, Jackson M. Andrews, minority counsel, and Patricia Markey, professional staff member.

Senator Cranston. The hearing will please come to order.

This morning the Subcommittee on Child and Human Development begins a series of hearings looking into the problems of abuse and neglect of children residing in institutions or group residential settings. This is an extremely troubling subject for those concerned about the welfare of children. It is also one which appears to have attracted very little in-depth attention. Despite repeated stories of incidents of serious and brutal maltreatment of children residing in institutional settings, there does not appear to have been a systematic examination of the scope of this problem on a national basis. This is all the more troublesome because many institutionalized children are supported by Federal funds, such as those provided under title IV–A and title XX of the Social Security Act.

A recent HEW report tells us something about the potential extent of this problem. That report indicated that over 400,000 children in this country live in residential institutions and that an additional 400,000 children live in foster homes. There are almost 27,000 foster children in California, with approximately one-fourth of these children living in group homes or foster care institutions.

The purpose of these hearings is to obtain information on both the scope of the problem of institutional abuse of children, and to learn more about the activities of various groups concerned about these problems.

Two Federal agencies carry out activities in this area: HEW, through its National Center on Child Abuse and Neglect; and the Justice Department, through its Civil Rights Division and Office of Juvenile and Delinquency Prevention. Last year I sponsored an extension of the Federal Child Abuse Prevention and Treatment Act. Under the provisions of this act, States which receive Federal funds for child abuse programs are required to establish a mechanism for the reporting and investigation of all child abuse and neglect—including abuse or neglect of children in institutions and out-of-home settings. Despite the fact that 42 States, including California, receive funds under the Federal Child Abuse Act, there are indications that very little has been done to develop systems for the independent investigation and correction of institutional abuse. Several months ago, candidly recognizing the lack of implementation of these requirements in States participating in the program, HEW specifically focused its first four grants under the Child Abuse Act demonstration project authority on the problems of institutional abuse of children. Later this month, the subcommittee will be holding a followup hearing in Washington, D.C. At that time HEW representatives will be testifying about compliance with the Child Abuse Act requirements regarding abuse of children in institutions.

In addition to HEW's activities under the authority of the Federal Child Abuse Act, the Department of Justice, over the past several years, has engaged in litigation on behalf of institutionalized children in situations where fundamental constitutional rights against cruel and inhumane treatment have been violated. Legislation to insure the continued ability of the Justice Department's Civil Rights Division to protect from abuse institutionalized persons, including children, was proposed by the administration and made progress during the last Congress. This legislation will be considered again early in the 96th Congress.

The Department of Justice has also been involved in the problems of institutionalized children through the activities of the Office of Juvenile Justice and Delinquency Prevention in carrying out the provisions of the 1974 Juvenile Justice Act, particularly with respect to the institutionalization of the status offenders—children who have not committed any criminal acts, but who in the past have often been imprisoned and subjected to harsh treatment.

The subcommittee has received reports of runaway children being confined in iron cages, held in solitary confinement in leg irons and handcuffed, tear-gassed and placed, as punishment, in dormitories with older inmates who sexually abuse them. We have heard reports here in California of children confined in institutions which rely on physical punishment and food deprivation as well as solitary confinement under the guise of treatment techniques.

One particularly distressing aspect of this problem which has recently come to our attention is the allegation that a number of foster children were placed by local government agencies into facilities operated or sponsored by the People's Temple. We have heard reports that as many as 150 foster children in California were placed with Peoples' Temple homes. At least one foster child from Alameda County placed with People's Temple members is confirmed to have died in Jonestown. At this point, the precise number of children involved is not known, nor the circumstances under which the children were placed with the People's Temple or removed from the United States.

I am particularly concerned about the abuse of these children and others as a result of weaknesses in our laws governing the care and supervision of foster children. During the last Congress, I was deeply involved in efforts, supported by both the administration and numerous concerned Members of Congress, including my colleague from California, Representative George Miller, to seek enactment of major reforms of the Federal foster care and child welfare program.

These reform measures were approved in very similar fashions both by the Senate and the House of Representatives, but we were unsuccessful during the last days of the 95th Congress in achieving final passage of this legislation due to tremendous time constraints. These reforms would have required closer supervision of foster children, periodic placement reviews, and detailed case planning for each foster child. Although we do not know for sure whether these reforms, had they been in effect in recent years, could have prevented the involvement of foster care children in the Guyana tragedy, they certainly are the kinds of protections which are urgently needed to preclude children being lost in foster care limbo. Because we do not now have the facts about the degree of involvement of foster care children in the People's Temple and Guyana, I am asking the General Accounting Office, the investigative arm of Congress, which 3 years ago conducted an investigation of foster care programs, to conduct a full investigation of deaths of foster children in Guyana and the use of Federal funds for foster care of children by the People's Temple or its members. I am also asking the General Accounting Office to provide me with an evaluation of the foster care reform measures considered during the last Congress in terms of the involvement of foster children in the Jonestown tragedy.

I intend to lead a renewed effort, along with George Miller, during the 96th Congress to secure enactment of these long overdue foster care and adoption reforms, taking into account the recommendations of the General Accounting Office—and I suspect that much of what we learn during these hearings will increase the urgency felt by Members of Congress to see these measures enacted into law, and thus free many thousands of children from the limbo of foster care.

We will now proceed with our first witnesses, and this will be the first of several panels, starting with Phyllis Kaplan, San Francisco; Marie White, Sacramento; Jolly K., of Parents Anonymous, Torrance; Kathleen Gresher, of Berkeley, Calif.; Terry Hopkins, of Santa Clara, Calif.

I would like to explain this first panel is basically parents and lay people deeply interested in this problem who will give us some examples of the sort of circumstances that we are concerned about.

If you will proceed in whatever way you choose and whatever order you choose, recognizing that we have some severe time constraints if we are going to cover a large number of witnesses today.

Would you introduce yourselves, please?

STATEMENT OF DR. PHYLLIS KAPLAN, SAN FRANCISCO; MARIE E. WHITE, SACRAMENTO; JOLLY K, PARENTS ANONYMOUS, TORRANCE; KATHLEEN GRESHER, BERKELEY; AND TERRY HOPKINS, SANTA CLARA, A PANEL

Dr. KAPLAN. Senator Cranston, I am Dr. Phyllis Kaplan. I'm a professional. I'm in educational psychology. I teach at Cal. State

University at Hayward, and as all of us here, I am first a human being and second a professional. I have been invited here today to speak because of my involvement with foster children and institutionalized children and because of my direct involvement in closing down an institution here in the State of California which I would like to describe to you.

I have written some comments in talking with Susanne, and I would like to also share some other feelings.

The fact that we are studying foster homes and institutions leaves me with almost no words to describe the horrors that I have encountered in the name of taking care of our children. I have seen more hopeless eyes and tattered clothing and children with looks of endless boredom, starvation, abuse, neglect; and there are no words with which to sit down today and describe them to you.

We're investigating this matter now, and I really appreciate your concern and can only wonder when we are going to stop warehousing these tiny human beings. I don't know, in this country, what more we need to be shocked by before we seriously demand changes, and I know you are working hard at it.

The sad thing about many of our foster children and many of our disabled is their inability to speak for themselves, and I think we all have to speak for them.

We can no longer, as far as I am concerned, justify conditions that have existed for years and years that we have known about, that we have been shocked about; and in my own personal experience, I remember being involved for 5 weeks with the Superior Court in closing down an institution; and a month later, people would turn around and say, "What? Oh, yes, I sort of remember seeing a picture of a cage on the front page."

When Susanne and I were talking the other night, there was a businessman at my home, and he turned around, listening to us and said, "You're not talking about something that went on in America?" I think that is typical of people's attitudes. They see it happen and they are shocked. They see it on the news, and then it's forgotten because it is not their child or their relative.

As I mentioned earlier, I'm a professional; but first I'm a human being, and my eyes, my gut reactions, my instincts are no different than any of yours. My nose can smell the stench just as yours can. My eyes can see the injustice just as yours can. My arms can feel the terror in the body of an abused, neglected human being just as yours can. My ears can hear the screams for help just as yours can. I must also add, my ears can hear the talk about tax cuts just like yours have too, I'm sure, every day.

It has been said, and we've all heard this comment, that you can judge a nation's humanity by the way they treat their children and their handicapped; and I know, Senator Cranston, that all of us here are beginning to wonder, despite the fact that we're proud to be Americans, when we are going to stop treating these human beings this way for a number of reasons:

One, because it's immoral, illegal, and ridiculous, and

Two, because I think we have got enough studies and enough evidence to prove that as these children grow up, they become very costly to our Government, so it would be very wise for us to take care of them at an early age.

I have to say that there is no amount of money that can bring commitment and concern to the hearts of caretakers who see this as a get-rich-quick kind of thing when they open institutions. This is not in any way pointing a finger at all caretakers of all institutions or all people who run foster homes; but there are a number of them that I see, one that I have been specifically involved in and a number that I have been peripherally involved in, where we have helped close down institutions, taken children out, moved them, et cetera.

One of the frustrations I deeply feel is the fact that I spend a good deal of time, Senator Cranston, fighting with people in the Health Department and in the Social Welfare Department to save the lives of the very children they claim to be concerned about. I think that they should be on our team. I think that when someone like myself or a parent walks into an institution and finds a child or a group of children and adults being neglected and abused, I think that they should join in closing down the institution. It took us approximately 3 years from the day I walked in until the day we went into court to close Oak Creek, which I would like to briefly describe to you, and I would like to submit the final document from the court case. But we have a comment here that I would like to share with you under No. 9:

> The evidence was overwhelming that corporal punishment was inflicted upon the residents by the staff and by the defendants personally, that the employees and the staff would physically strike the residents, that various restraints were used by way of straps, sheets, et cetera, completely without medical authorization or direction, that residents would be tied to chairs or tied to their beds for lengthy periods of time. Residents would be forced to sit in their own feces or urine for long periods of time * * *

and it goes on and on and on.

I am also a mother of one of the children I found in this institution. I found him when he was 5½ years old. I got him out a year later, which was about 2 years before the whole institution was closed. I live with him. He's presently in a private school. He has lived in my home with me for 15 months. He is now in a really fine private school in northern California called Trinity. I lived with nightmares. I lived with screaming. I lived with absolute fear. I lived with hyperactivity. I lived with problems that I can't begin to describe to you that result from a child being in 9 or 10 foster homes or institutions.

I have also followed up a number of the other children who have "escaped" the particular institution that I am talking about.

I think the testimony from the court case is available, and Susanne has part of it, and you certainly are welcome to read it or have a copy of it.

What I have to say is I was a volunteer in Vietnam where there was a lot of terror and a lot of heartbreak for kids, and I have followed those kids up, too; and the kids from Vietnam who lived through the war seem to be in much better shape than the children I see who come out of numerous foster homes and institutions.

I'm deeply concerned, as I know you are, about subsidized adoptions. I cannot adopt, for example, my son. A lot of these children cannot be adopted legally because it is so costly to the kind of services and care that they need at this point: Psychiatric services, residential treatment, et cetera.

I'm concerned about the fact that these children go from home to home and never have a family. I'm concerned about the fact that when I was talking with a social worker the other day and I said, "Well, I understand these two children that I was concerned about who were once at the Ranch have just been moved. Is it a better foster home?" and the social worker looked back at me and said, "No, Phyllis, not better, just different." They were removed from their last foster home, I am told, for abuse and neglect. It's a nonending thing.

As I said earlier, I don't think any amount of money, Senator Cranston, can change it. I do take a look at the place like the school that my son is in, which has a more than one-to-one ratio of staff to children, which has sane working conditions, you are on 3 days and you are off 4 days, so that no one gets burned out so they end up abusing and beating children.

I have often been asked what it was like when I walked into the institution, and the first thing I remember is the stench of urine and feces and vomit and other such things. I remember looking in the eyes of 63 lifeless adults and children.

I, myself, have not witnessed the homosexual abuse that has been proven in the court case. I, myself, have not witnessed the cages that were built to place these children in because they were built after I was removed from the institution. Several of my students from the university were teachers there, so I got to see the children who were brought out to the university because we could no longer run a school there.

I don't want to spend time this morning talking about one specific institution. This institution is closed Senator Cranston. There are hundreds of thousands of children in our State and throughout the United States, as you well know and as you well stated, that are in homes, repeatedly moved, that are in institutions repeatedly being abused and neglected. My concern about the children in People's Temple is the same, as I am sure, your concern about the children in People's Temple. It seems that whenever we can find a niche to place a child, we just put him there. We don't worry about diagnosis. We don't worry about good homes. My own "son" Andy (S-u-n), who, at this point, is a child who, when I found, was considered severely retarded. He's a child who for Christmas got the paperback book "Roots" and several other paperbacks because he is reading above grade level.

The only thing that is wrong with my son today, Senator Cranston, is that he can hardly sleep, that he is extremely hyperactive, that he's fearful, that he's been homosexually abused, and that he has a lot of very disturbing problems that we hope some day he will be able to get through. He is a very bright child who was misdiagnosed at birth. I need to go back to the agencies and say that they were told and that they knew—and when you read the court hearings if you get a chance, you will see that people in the agency have since been removed from their jobs for not doing their jobs—but I remember going to the Health Department and pleading with them to take a look at what was going on and being told that their concern was with the dust in the corners and they could do nothing about the treatment of children. There are endless calls and letters in my files to the social welfare departments and to other agencies begging them to join us, to come out and take a look; and the sad thing, Senator Cranston, is that no one wanted to join the winning team until it looked like we were really winning and the place was being closed down. I think we have to really take a look at the standards that we have set, that children have their own clothing, that they have decent food, that they have the right to contact their families, et cetera, and that we really do enforce these laws.

I don't think that any agency itself can enforce these laws. I think we have to be much more careful about the kind of people we choose to work with children; and, as I mentioned earlier, I think we have to realize that some of these children are so demanding that any institution that goes out and hires numerous people at $2.50 per hour and lets them work 7 days a week, 8 hours a day, cannot be expected to treat children humanly because these children have too many needs.

The particular institution that I was in had over 60 children and adults and had maybe 2 or 3 staff people when we were lucky. It went on for years and years and years; and for what I am told, the people are still able to work with children today, so that our work in ways was not in vain because those children are free, but other children are not free.

I visit institutions all the time about which I think, "Well, we have got to do something about this—this is another place that has got to be closed"—and I turn and find myself just absolutely unable to get the kind of support that we need to continue to do this.

I mentioned subsidized adoptions before, which I am concerned about. I mentioned the need to give these kids some kind of stability. I would like to share with you that my son, when he was home for Christmas, decided he was going to adopt his own family. We have found his natural family. It has not worked out, not that I wanted to give him away, but I wanted to share—he was in school with his sister, and it turned out that we had to do some legal things and make it possible for him to meet his family; but the reality is he now wants to turn around and pick this person as a grandfather and this person as an uncle, and me as a mother, I hope—et cetera; but I cannot, as I said earlier, adopt him and give him that security; because it is very, very expensive to get him the treatment he needs.

What happens to these children later, you know and I know—whether it's imprisonment, whether it's confinement in an institution, whether it's extended therapy, whether it's just a lifeless boring life of unemployment and hanging out in the middle of any city in our country—I wrote my son a poem, Senator Cranston, which I think describes where all the kids are at years ago, which I got to read him the other day. He was living in a foster home where it was demanded that he call his foster mother mama. I wrote him this poem, and I said:

> **Andy, I want to hold you in my arms. I want to tell you the story of your life. I want to solve the mysteries that must haunt your heart and soul. I want to tell you how proud I am of you. I want to free you from your fears about being retarded, rejected, unloved; but, little one, I can't hold you in my arms like I used to do, for you have grown up, your mama calls you "papa, her little man."**

He had called so many people mama by that point that mama had no meaning. Andy once looked at me and said, "You know, mom, everybody in the world is a bar of soap. You use them up; they go down the drain, but you're a lifetime box of Fab." I think that represents how a lot of our kids feel about the multitude of people whose lives they share; and, indeed, that's what it is all about.

You want to be a senator—my heart smiled when I read that in your school newspaper, you know, the one in which you wrote the story about Chief Joseph and the one in which you shared your Christmas joys. Andy, you can be a senator or whatever else you want to be, Little One, but I want you to know, for me, you will always be the rainbow, the smile in my heart. Yes, I remember when you were tiny and fit into my lap. I remember the tears at sunset when you had to be taken back to the institution,

Which I, illegally, Senator Cranston, took him out of on Sundays because no one ever knew he was gone.

I remember it all, like it was today, chunks of my heart and soul went with you into confinement, to the unknown of the pit that society had wrongly placed you in. Yes, I want to tell you the story of your life, but, I can't. You are a tree; strong, beautiful, blossoming. I can tell you what you mean to me, but, Baby, I can't tell you about your roots. You've got them. Every human being has roots; but yours, My Love, are buried in the lifeless, disinterested files of the social service department; and even if I ever get to read them all, they will be incomplete. You know, as you believe in the sunrise and sunset, as long as you can flow with the wind, you will exist and live in your own self-determination, and for damn sure when your little ones grow up, you will be able to tell them about their roots. Your mama loves you, and so do I, and God loves you. Sleep little one and keep believing.

This is not just about my son, Senator Cranston. This is about thousands and thousands and thousands of children who do not sleep at night, who are hyperactive, from absolute, positive fear; I'm convinced as a pro and human being.

I do not know how to control or how to put controls on the agencies that make friends with institution owners and refuse to walk through the doors and take a look at what's going on behind the doors.

There are people sitting in this audience, two of my students who weren't lucky enough to just be the consultant that was sent in and ended up walking out because I could not seem to get the owner of this particular institution to understand about humane treatment.

There are people sitting in this room today who took care of children who were never medically taken care of, who were obviously homosexually abused, who were obviously starving. There are nights that I not only live with Andy's screaming and yelling through the entire night, but also there are nights that I cannot forget the moldy bread, the rotten food, no toys, the television room with 60 people packed in, the children and adults screaming up and down the hallways.

I am going to, as I said, submit the final judgment of that case. I think you will find it interesting. It talks about things that I have not had a chance in 10 minutes to talk about today. I just want to express my deep appreciation and say that I am personally available, Senator Cranston, to help in any way possible. It's a very hard subject for me to write about or talk about, because it's not only a subject that I am professionally involved in, but I am a mom and I am a human being like the rest of you.

Everything that you have said this morning is true, and more. People have written books. People have shocked people. Willowbrook was the shock that hit television. Oak Creek Ranch was a shock. It hit television. It hit the newspapers. So what? I'm still dealing with people who turn around to me—just 2 days ago, in front of Susanne, your lawyer, and say, "But this is not in America?" "Yes; it is," and I appreciate your support.

Thank you.

Senator CRANSTON. Thank you very, very much for a beautiful, eloquent, forceful statement which is a very fine beginning for our efforts to learn more about this. Thank you. We will count on your help.

Dr. KAPLAN. I would like to mention that I am on a sabbatical and I am leaving the country in 2 days, and the only reason I am here is because I really believe in what you are doing or I would have left a few days ago.

Senator CRANSTON. You'll have to cancel those plans.

Dr. KAPLAN. I have to cancel those plans? Thank you.

[Information supplied for the record follows:]

10

A MODEST DISPOSAL

by Ruskin Goodenoff

Founder of the Institute of Mental Myopics

Translation: Medora Roric

16

The following paper is a translation from a tape discovered in a dusty back corner of the Ad Hoc Object Shop (Leftovers from a machine age banquet) on Sixth Avenue and Canal St. in New York City. After extensive research, I was able to uncover the following information. Ruskin Petrovich Goodenoff was born in 1903 in Rumania and migrated to the United States to study psychology at the New School of Social Research. For many years he worked as the founder and director of the Institute of Mental Myopics, dedicated to furthering research in the field of mental retardation. Anticipating the response to his proposal, he later began training in Veterinary Medicine, and was last heard of studying bird life in South America where it is rumored that he died from stomach cramps after eating the native dog soup.

A suggestion for advertising the proposal was also found with the tape .

> "The late apparent spirit of humanism, or love of psychology, so abounding of late, has produced a new scheme wherin the author ingeniously advises that one-fourth of the retarded population be bred and the remainder be sold for pets, reasoning they will be much happier than their current miserable life as human beings."

Medora Rorick

It is a melancholy sight to those who visit this great country's institutions for the mentally retarded, to see the miserable poverty and cheerlessness of their lives - the endless corridors, the absence of privacy, the unending frustration of trying to learn the required reading, writing, and arithmetic (or if less advanced, dressing, speaking, and continance) and the almost universal hunger on their faces as they crowd around you for a pittance of affection and love.

I think it is agreed by all concerned that this miserable state of affairs is not only inhumane, but a very great additional burden to the State's treasury, being estimated to cost between $200-600 per month per person.. Therefore, whoever can could design a just, cheap and reasonable way of making these children sound and useful members of their community would so well deserve of his effort, as to be rewarded the nation's highest esteem.

It is true, a child, regardless of native intelligence, is rarely any great additional burden on his parents for the first year of life, but as soon as it has been detected that their child does not walk, talk, or handle a spoon so soon as other children, then begins an endless round of doctors, examinations, prognostications and definitions which do little to relieve the parent's anxiety, or growing sense of guilt reflected in such statements as - "I always knew we shouldn't have gotten married" or "What did I do wrong" and often ends up in institutionalization of the child anyway. But what if a scheme were developed whereby, instead of being a burdeh upon their parents for the rest of their lives and a great cost to the State, these children could contribute to the happiness of millions, and themselves be happy too? For there is another great advantage to my scheme, which is that it will prevent that crippling sense of being unwanted these children so often exhibit, a sight which should move tears and pity in the most savage and inhuman breast.

As for my part, having turned my thoughts to these problems for many years, in fact, devoted my career to their study, I have always found the workers in this field to be grossly mistaken in one basic assumption - that mentally retarded individuals are the same as other people, only slower, and can be raised and educated as human beings.

I shall now humbly offer my own thoughts, in hopes they will not be liable to the least objection. I have been assured by a trusted local pet merchant that a child under the age of five is a salable commodity. A young child, well nurched is at a year of age, a most attractive and inspiring sight, whether deaf, blind, crippled, or retarded, and I am sure tis equally true of those that are autistic and gifted.

I do therefore humbly offer it for general consideration that of the estimated 100,000 retarded children born each year, one-fourth be reserved for breed, and the remaining be offered up,for sale at the age of one or two years, to persons of quality and fortune throughout the fifty states. I grant this may be somewhat hard for the parents, who having raised their child to the age of two, may have become emotionally attached, but it is necessary for my scheme to work, and for the welfare of the retarded themselves, that no attachment to these children as human beings, be allowed to interfere with their ultimate happiness.

I think the advantages of my proposal are obvious and many, as well as extremely important. Of greatest interest to the State will be the matter of cost. Contrasted to the average $500 per head per month cost now maintained by the state, in addition to numerous personel, building costs etc., is the relative inexpense born by the individual family of means. A retarded pet will cost less than your average German Shepherd to maintain. Unlike a dog, which needs special and costly pet foods, the retarded pet can eat the leftover scraps from the family table. In addition, a retarded pet owner will forego the costs of rabies shots, registration fees with the American Kennel Club, dog collars and tags (unless by owner's choice), and special grooming tools. In addition, the retarded pet can be taught more - he can walk on two legs, as well as four, talk, run errands, is affectionate and grateful, and his bite is not dangerous to man.

The parents of the retarded will be rid of the debilitating guilt they presently suffer from, and cost of educating these children as human, which, as they will tell you, is very high indeed, and long and tedious also. In addition, this scheme frees up educators to teach only those who can learn, rather than dealing year after year with the frustration of seeing their efforts bear no fruit.

A whole host of new jobs will grow up around my concept, thereby providing aid to the nation's economy (of which it is sorely in need). Pet stores will abound and neither will managers be found wanting, for administrators and supervisors of our present institutions will find it an easy transition from their current duties to that of pet dealers. Books on the subject will be everywhere popular, such as "Know Your Retarded Pet", "Enjoy Training Your Retarded" and "How to Keep Retards".

Doctors will no longer have to be embarrassed about breaking the news of retardation to parents, since they will be able to assure them that the future is bright for their child as some lucky family's favorite pet. This will necessitate no great changes in their current practices, but will allow them to be more direct in their choice of words.

And of course, the greatest advantages accrue to the fortunate children themselves. No longer will they have the experience of being a great calamity and burden of their parents, and rejected and unwanted member of the human race. Experiments have shown that the average American pet is touched, held and given affection fully ten times as much as the American child. And as pets, they will outshine even the best. No longer will it be the new pedigreed dog that is brought out for everyone to admire, while Johnny is locked in the closet. Now he will be trotted out as the most enviable of pets - for everyone knows a retarded pet can run circles around a German Shepherd. In our experiments at the institute, it has been shown time and again that a hungry retarded child reaches the bananas at the end of a maze an average of 15 seconds faster than a dog, and fully 55 seconds faster than a cat or raccoon. Not only that, but his general resemblance to a human being, those 5 cute pink little fingers (if you get one fully equipped) make him an ideal plaything for adults and children alike, especially little girls who like to play with dolls.

In our pilot project, apartment owners reported that the retarded pets chewed up 50% less furniture and 80% less shrubbery. The gardner reported having to pick up fewer turds since 90% of retards can be trained to use the toilet, whereas according to our surveys, only 5% of the pet population has yet accomplished this feat. The only disadvantage consistently reported by apartment dwellers was the size of the pets. Plans are already in progress for developing a toy breed from the one-fourth retarded population reserved for reproduction.

For those pet owners who enjoy variety, "Rent a Retard" and "Pet Swapping" businesses are sure to thrive.

Many have expressed concern about traveling and the retarded pet. Of course, they could be shipped air freight for minimal expense, but if this is not acceptable, the President is currently introducing a bill in congress for day kennel care for the retarded. This should be particularly helpful to working owners, Pet shows for the retarded will spring up everywhere, and can be modeled after the Special Olympics, in such current fashion today. In addition, seeing eye retarded may prove infinitely more valuable to their owners than dog guides; in fact, the practical use of retards as pets is almost unlimited, as evidenced even in these backward times by sheltered workshops.

A few basic guidelines for prospective owners are in order:

1. In choosing your pet, first compare the size. Your's is neither the largest, nor the smallest. Be sure to check for toes, fingers, ears and eyes. Your pet will be cute and floppy, but also awake and curious.

2. Flea collars are an absolute must if your pet has been in a low grade institution. You may think he's just abnormal when he sticks his fingers in his ears, but it may be fleas.

3. When you bring your pet home, let him sleep the first night in a snug box. Set a metronome nearby to remind him of his mother's heartbeat. Gradually introduce him to outdoor sleeping in warm weather, so he won't have any excuse to be indoors.

4. When training, be firm and consistent. Use the same words for each lesson and say his name each time before you ask him to do something. Be patient and reward him with kind words and stroking. Shouting will only confuse him. Keep the lessons short.

Having for many years wearied myself out with vain idle visionary thoughts, and having fallen into great dispair, I fortunately came upon this proposal, which, since it is wholly new, has something solid and real about it, is of no great expense and is little trouble in its excution. I would gladly listen to anyone else's plan but ask if it be equally innocent, cheap, easy and effectual. I can think of no one objection that can possibly be raised against my proposal unless it be concern for those older retarded people alive now who are past the age of being selected as pets. But philanthropic souls may rest assured, for it is very well known that they are everyday dying off by frustration, loneliness, restlessness and sheer boredom as swift as may be reasonably expected.

Finally, I desire those who dislike my proposal to first ask the retarded themselves, whether they could not, to this day, think it a greater happiness to have been sold at a year old as a pet and raised as a beloved member of a warm family than to have endured such a perpetual scene of misfortunes as they have since gone through.

Senator **Cranston**. Who's going next?

Ms. **Jolly K.** I'm Jolly K., founder of Parents Anonymous. I'm also a person who, at 39 years old—38—lived a childhood that involved 33 institutions that I was placed in and 30-some-odd foster homes.

I want to preface this by saying that I really consider myself to be a pretty tough cookie. I take life on the cuff and take it as it is and go on battling the windmills or whatever; and last night I was watching television, and all of a sudden I started crying and carrying on and feeling really depressed and everything else and wondering what, you know, what gives. You know, my public image is at stake. What if I break down crying at the hearings tomorrow? Oh God, I can't afford that. I'll embarrass the Senator, you know, a weak broad and all that jazz—and—come on, shape up, so I called my husband, and "Joan, honey, are you down in the dumps, and what's the matter?" "I don't know, it's just silly." "What do you mean?" I had blocked coming up here from remembering until last night the first institution I was ever in was in this city. I was 4 years old and my mother had abandoned me, and I was placed in juvenile hall. That was also the first time I ever saw the inside of an isolation room; and we've gotten a little more sophisticated—nowadays we call it, and this will fit in real good with a lot of people—we call it meditation room. "They are teaching us youngsters how to meditate," or other euphemisms such as "quiet room." In my written testimony, I recommended that possibly we might issue the staff hearing plugs so that they don't have to hear it, so that we can go ahead and discharge some of the anger and distress that is going on with us children when we're kept in such places. As she described, 33 times over from the age of 4 until I was 18, I was a guest, I was a protected child.

Senator **Cranston**. How many times over?

Ms. **Jolly K.** Thirty-three. I was placed into institutions 33 times. Some of those were repeated. In other words, some were in the same place. Los Angeles Juvenile Hall, by the time I was 13, I had been in the L.A. juvie 11 times. Also, at the same age, at 13, I had been in Long Beach Juvenile Hall four times; Bakersfield Juvenile Hall, twice; Portland Juvenile Hall, at age 9—I spent my 10th birthday there. I don't remember my 10th birthday.

We talk about, a lot of words at the roots. It's been made known to us how vitally important it is that people do know something of their own personal roots. My roots come in paper from about 3 inches thick, what's left of my juvenile record.

I don't even have memories of childhood until I'm 13 years old. I have scattered bits. I can remember the day my mother took me in a cab and dropped me off at a lady's house, promising to come back and take me to a movie after I took my nap. Then I remember being in San Francisco Juvenile Hall. My mother never came back until sometime later. I don't remember when.

An abandoned child and I end up in juvenile hall? Is that my crime, to be abandoned? That I should be incarcerated in the same type of place that we would put a juvenile who murders, a juvenile who steals cars, a juvenile who vandalizes, a juvenile who performs arson?

I know when I got out of the Convent of the Good Shepherd in Los Angeles when I was 11 years old—or 12—sometimes the only way I could remember my birthdays was to keep track of where I was at. Oh, I know where I was when I was 11. I was in the Good Shepherd Convent. My mother asked me what I had learned at the convent. I told her, "Mom, I learned what those funny little brown cigarettes are. I learned how to roll them. I know why you take a spoon and twist the handle up and why you hold a match under it. It's called marihuana. It's called paraphernalia. It goes with taking heroin. I don't think I was ever out long enough on the streets to connect with people and get into it."

How do I talk to you about my childhood in institutions when it involves 33 places? I can't keep them all in my mind in chronological order.

Senator **Cranston**. You're doing it beautifully.

Ms. **Jolly K.** Some of the things I'd like to particularly point out, the years that I spent drugged, the fact that I do not recall being under steady medical care while Thorazine and other types of medications were being given to me. I do not once remember being diagnosed as hyperactive or so severely ill adjusted or mentally unhealthy, or the various words that we use in that, that would justify the many years that I was kept under that medication. I can't speak for the other girls. Maybe some of them did receive legitimate diagnoses by people specifically trained to look for and justify these diagnoses rather than, say, a general practitioner of medicine. All I know is that most of us were under medication.

Some of the things that I wrote about in my testimony—the humiliation—you're always in the institution, but the humiliation of some of the things that occur, less graphic but more cutting than some of the things you will hear in the testimony today—what it feels like to be a young female and be in isolation, being locked up, where there's a door to your room and then within that door there's a smaller door in which your items, your food, items of soap, toothpaste, toilet paper, and Kotex, are given to you. Most of these smaller service doors are located at the bottom of the door.

My toilet paper and my Kotex was slid across the floor to be placed against the most intimate part of my body. Think about that just for a second. I don't know how men can associate with that. I don't know that men have to place items inside of their shorts against—unlike women, they don't have to worry about Kotex. Of course, they do use toilet paper. That's an intimate part of a male's body. How would you like, No. 1, to stoop over to pick up toilet paper and then take that same toilet paper that's come across the floor and wipe your ass with it. It robs you of your dignity as a human being to have to stoop over all the way to the floor to pick up your food, like you're some animal.

Thirty-eight years old and I still have to live with these. I can't even afford the counseling to undo some of these damages, so I pay for it as a kid. When I get out of it, I'm asked by society, you know, I'm expected to conduct myself as a functioning person in an open society. I'm expected to have children. You know, if I have children, I'm expected to parent them. From where do I learn to do all of these things? Where are my models? Where are my examples?

One of our people in the office of Parents Anonymous, Margo Britt, said that 25 percent of her chapter is composed of parents who were institutionalized—25 percent of that one chapter. We don't know about the other close to 1,000 chapters we have, how many parents were in them, and if that means anything or not, if that's significant.

I'm tired of paying and carrying the pain that's still in there from over 20 years ago. I'm tired of having to be the one that's in debt. I have over $3,000 worth of bills that I owe psychiatrists presently today that I have to pay to undo the types of damages—and I don't have that kind of money. So it's either can it and not get help or go into debt to pay for it.

I spent over 4 years of my life in isolation, one time over 4 months straight in lockup. In boredom, I used to tattoo my body. I used to break rules in order to get the stuff to do the tattooing, and then broke further rules by doing the tattooing. Some people will notice that I have a blue dot on my lip. That's a tattoo. From my head to my feet, whereupon right above the sole of my foot there's a little star tattooed. The State, in its benevolent goodness, did remove several of the tattoos when I turned 18.

What about the stars? What about everything else, or do I write those off? When my husband looks at my body and sees the scars and the ink still is in some of them, and he kind of turns away, you know. Do I just write all that off? I don't know. I don't know what to make of all this. I don't know what the answers are. I don't know if a committee hearing, if several of these can change these conditions or what. I'm just telling you what some of us have to live with, and I'm going to some of the smaller kinds of items, the fact that many, many years later that pain and those scars still exist.

I want to thank you very, very much.

[The prepared statement of Jolly K. follows:]

Written Testimony Respectively Submitted to the Subcommittee on Child and Human Development

By: Jolly K., Founder and Consultant, Parents Anonymous

RE: Senator Alan Cranston's (D-California) hearings on institutional child abuse

Item: Child confined for indefinite stay in solitary confinement.

Reason: Continuous uncontrolled loud crying. Such behavior could insight further destructive behaviors by self or other inmates. When questioned as to cause of such behavior, child merely referred to a letter just received from her parents. Letter said parents would not visit as formerly promised.

Item: Child confined to solitary confinement for indefinite stay.

Reason: Child used excessive foul language to staff, then struck matron.

Cause: Provocation of behavior unknown.

Item: Child confined to solitary confinement indefinitely.

Reason: Refusal to eat meal.

Cause: Provocation of behavior -- child says she is too upset and does not want to eat.

Item: Child confined to solitary confinement.

Reason: Instigated and participated in riot, destroying institutional property and endangering life.

Cause: "Says she's sick of the stupid rules and use of solitary confinement." "Further says it is unfair to be thrown into solitary for crying when parents break their promises or because she is too upset to eat" and "that it doesn't make sense to her that matrons can treat her that way and yet lock her up when she cusses or stands up for her rights in the only way she knows how."

The indiscriminate use of solitary confinement for youths already under lock and key strikes me as being the most demoralizing and dehumanizing abuse of children in institutions. The four items listed above are just fragments of other untold similar occurrences. I am speaking from personal experience. Those four items represent me from age 4 until age 18.

The states of Oregon, Nevada and primarily California, acting on my behalf, deemed it fitting that I be placed a total of 33 times in various institutions. Collectively, for four years, the first when I was four years old, while at San Francisco Juvenile Hall, I was placed in solitary confinement. Four years of my life were spent in rooms that are physically representative of solitary confinement rooms commonly found at such places as Folsom Prison, Sing-Sing and Atica.

I long ago made the decision that what we have in America is not a juvenile justice system. It is a juvenile injustice way of systematically abusing children. I and thousands like me know all too well of the abuses described in this text and other abuses that I will offer in verbal testimony to the Subcommittee on Child Abuse and Human Development -- a most appropriate title for such a Subcommittee who investigates this type of social injustice of children. Should a child be so unfortunate as to be caught in this system, they will need congressional subcommittees and action in order to achieve human development.

It is easy to talk of individual adult behavior that thwarts or destroys human growth and development. It is easy to acquire a sense of righteousness and indignation toward such individuals who destroy children. It is braver and more difficult to call attention to institutional child abuse. To do so calls for looking at large administrative bodies who set institution policies that allow for injustices, administrative hiring criterias for staff members who may or may not humanely carry out administrative policy, and who set the budget at not a small sum to the taxpayer for this system to continue.

On many occasions I personally witnessed girls, fellow inmates, in the general age bracket of 13-17, being assaulted and injured by adult staff members. Many times I witnessed girls being jumped and beat upon by groups of other inmates while an insufficient number of staff personnel stood by doing nothing. I, myself, feared greatly that that might have occurred to me with no adult willing or able to provide protection for my safety. This fear was common among the inmates.

In solitary confinement, personal hygiene items such as toilet paper and Kotex, as was our food, were passed through an opening at the base of the door. I can't begin to express the dehumanizing effect of using toilet paper or Kotex next to the most private and intimate part of our female bodies after having seen those same items sliding across an unmopped floor. Under these conditions, how dare they refer to Kotex as sanitary napkins! And how long can a young child regard themselves as human when, like an animal, their food is passed to them on the floor? We were forced to stoop that low to pick up our food in order to eat and nourish our bodies.

Who justifies policies that allow for adults to stoop so low as to carry out such horrid practices on their wards? Granted, not all of these children were little saints. Certainly, some of the behaviors displayed by these youthful inmates warranted restraining methods in order to insure safety for all. However, indiscriminate use of solitary confinement, massive use of tranquilizing drugs and methods of physical restraint in which injuries occur are not an answer.

How can we justify the use of solitary confinement, with the degradation and deprivation of sensory stimulus so needed for child development, particularly in view of the fact that solitary confinement conditions used for youth are the same used for hard-core felons who break institutional rules? That is to say, an adult felon who knifes or kills an inmate or staff member would end up in the same type room as a youngster who uncontrollably cried, who deigned to be so indiscriminate as to sob 'too loudly', when their parents broke promises.

It is my understanding that at the time I most remember being given daily doses of the medication, Thorazine, as so many of the other inmates, the state of California had determined maximum dosage of Thorazine to be 400 mg. I, like many others as a youth of 14, was given the maximum dosage. I would suspect that adults in prison taking

Thorazine received the same dosage. How is it that 14- to 15-year-olds, with the givens of their physical development and metabolism, received similar doses of medication given to adults who have arrived at totally physical development? What research supports ethical long-term use and possible physical side effects? And what are we as a society to do that will effectively eliminate staff members from the payroll who misuse and abuse their positions of authority? Or are we to continue these practices?

Studies indicate that many youths come from abused homes. Society cries out in alarm and abhors such homes that abuse children. Certainly, if such individuals were to perpetrate upon their children some of the things I have described herein, court action would be taken immediately. Yet, when these children reflect disturbing social behavior as a result of damaging home life, the alternative is to place them in institutions to be systematically abused. The wounds so often caused from such care, or as so many of us know it as lack of care, are long-lasting and costly.

It is no small wonder that adult prisons are filled with former delinquents who prior to delinquency so oftentimes were abused children. How much salt in these wounds can a youth withstand? How many wounded youths can our society continue to allow? Is it not enough to have individual homes assaulting youths without social systems further incurring more emotional psychic scarring of our nation's youngsters?

When, as a nation, will we mature enough and become responsible adults adequately handling frightened, acting out children? Or must we continue to treat these 90-, 120-, 150-lb. terror-filled holy terrors with the same methods that are used for mature adult felons? Certainly, some distinction can be made. Where in these times, under these conditions, are our troubled youth, delinquents if you will, to turn under these circumstances? Where will they get true rehabilitation? Where will they receive humane conditions that enhance constructive development? Will it be the benevolent state who acts as guardian of such youth who carries out the system described by myself and others? If so, I have a word of caution to all of us -- "Duck, the helping protective hand will strike again."

I. Addendum

I submit the following recommendations regarding solitary confinement:

A. That all commitments to solitary confinement be done so with the determined prescribed time-limited stay. That the time-limited stay have a minimum and maximum use with time off for good behavior and be clearly stated to the youths. Any concurrent sentences should be treated in a similar manner.

B. That all youths in institutions receive upon entrance a clearly communicated list of rules and regulations along with minimum, maximum consequences.

C. That regarding "B," such communication be done so in a manner clearly understood by the child's ability to comprehend.

D. A child confined in solitary confinement have access to sensory stimulus materials, i.e., stuffed toys, magazines and other such items used by youngsters of their age group for recreation. That these items belong solely to the child. Should the child wish to destroy them, then this right is to be respected. Adult discretion shall determine which toys for stimulus shall be provided so that if destruction occurs the destroyed item cannot be fashioned by the youngster into a weapon that would harm the child or another person.

E. That under solitary confinement conditions the ratio of staff to youthful inmates be one staff member per every four inmates.

F. That the function of said staff be that which would create visual contact, oral contact, audio contact with their four charges on a regular basis except during normal sleeping hours, thus creating more normal sensory stimulus (discrete use of earplugs may be advisable under some conditions for the staff member).

G. That such staff be hired on the basis of their acquired training and demonstrated skills in the knowledge and practice of child development plus a rudimentary working knowledge of child psychology. Furthermore, that there be keen attention paid towards each staff member's attitude and respect towards troubled youth. E, F and G might also be advised for the hiring of any or all staff having ongoing contact with inmates.

II. Psychotherapeutic Drugs and Medication

A. Any and all psychotherapeutic drugs must be approved, ordered and regulated on a regular basis by a psychiatrist only. That it be recognized that a physician, without thorough training in psychiatry and extensive knowledge necessary to assess the type and effect of the drug in conjunction with a valid psychiatric diagnosis, is not qualified to dispense psychotherapeutic drugs in an ongoing fashion.

B. That ongoing use of such medication be authorized only after a thorough psychiatric and medical evaluation is completed to assure no physical or psychiatric contradictions or conflicts occur.

C. That the child's parents or legal guardian be notified, in a language clearly understood by them, of the type and all known effects of any such type of drugs being administered to the child. Most importantly, that all known side effects be stated clearly in writing to the child's parents or legal guardian.

D. That only well-established and widely acceptable psychotherapeutic drugs be used. That it be clearly understood that no 'new' drugs, with side effects, unknown and still to be researched, be ever administered to a child. That these children have the legal right to not be medication guinea pigs. That it be recognized that these children are not capable, due to their youth and ignorance about such medication, to consent to medication experiments or research efforts, and that no adult has the authority to give consent for use of medication to any child for research or experimentation. (I was very alarmed and concerned when I read in a medical journal that it has been determined that through long-term use of the drug, Thorazine, that one resultant side effect recently established is irreparable kidney damage.) As a youth, I was given, for four years, the maximum dosage of Thorazine, then allowed by the state of California. I had never been once consulted or asked for consent to have this drug administered to me. Even had I been given this right as a youth, I was ill-equipped to intelligently consent on my own behalf. Does any adult have the legal and moral right to have made this decision for me? If they do have this right to consent on my behalf, does this legally entitle me to claim damage should I suffer from side effects later, discovered once the drug(s) and the side effects are well-established? Or am I to mark it off as another institutional system(atic) abuse to me?

III. Ombudsmen to Represent Inmates

A. That an ombudsman be appointed one per institution and/or one ombudsman for every "X" number of inmates (intelligent ratio to be established -- no tokenism). The purpose of the ombudsman shall be to receive, investigate and evaluate validity of inmate complaints of abuse(s) suffered while in an institution.

B. That the ombudsman be visible and readily accessible for and to the inmate by means of non-censored mail to and from the ombudsman, or by phone should the child be unable to communicate in writing due to physical or mental incapabilities. The method for visibility might be as simple as a clear communication which is posted in a highly visible place for the inmates.

C. That all claims or reports of individual staff assault of a youngster receive the same treatment of investigation established by existing laws governing child abuse.

D. That any staff member having a complaint of child abuse lodged against them, and found to be valid, be immediately dismissed from any and all duties that would allow for staff/inmate contact. Furthermore, any such proven case of child abuse, with details and names of parties involved, shall be immediately sent, in writing, to the State Child Abuse Registry and kept on file.

Not possessing legal expertise, I am not certain as to how any or all of these recommendations can be legally employed or interpreted. I ask only that considerable thought be given to these recommendations. I am quite sure that a collection of minds, more knowledgeable, skilled and experienced than mine, if truly motivated on behalf of protecting children from abuse, could make a significant impact and subsequent needed change that would insure progress in this matter.

This, as all of you are probably all too aware, is not an easy issue to resolve nor does it bear immediate rewards for those who tackle this project. In consideration of this aspect alone, I offer my sincerest thanks, both personally as an individual and on the behalf of our nation's incarcerated children. Thank you all for your courage and commitment to this task of providing non-abusive treatment of institutionalized youth.

Respectfully submitted,

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Senator **Cranston**. Thank you very much for another very helpful statement. I'm delighted that you didn't decide last night not to come because it's very helpful to have you here. Thank you. Who's going next?

Ms. **Hopkins**. I'm Terry Hopkins, and I'm the parent of an autistic child.

When I was called by Susanne Martinez about these hearings, she said it was mainly on institutions, residential type of setting, and I said that, because my child was not in an institution, even though I have heard all the horror stories, that perhaps it would be helpful coming here because perhaps the biggest fear of the parent of a handicapped child is what will happen to him if you die, and this fear is exacerbated a thousand-fold by what you see happens to children when you are alive and well and monitoring the so-called type of treatments that they get.

I told her that I wasn't convinced that if I die tomorrow the State institution would be any better than what is out in some of the public schools, so-called community. I was afraid that the hearings would turn into a let's-save-them-from-there, even though they certainly need saving from there—and to maybe a place that doesn't smell so bad, some public school classrooms, some private school classrooms, where the lawns are nicely mowed and stuff, but there is still abuse of children, I feel, out here in the so-called community, and I would rather you think about that instead of rushing them all out into this other mess.

I've got a letter from a parent telling me about her child being abused at one of the State hospitals, and she was trying to get her child out. She said that when she went to visit, he had bruises, the whole gamut of things that you have just heard here, and she felt very optimistic. She said, "I can put him in a place out here," so I hate to tell her, "Guess what? It might be for less hours. You might have a better ratio."—I'm getting a little bit ahead of myself—I guess what I mean to say I think we have to broaden our view very much on child abuse. We are all inundated through the media of pictures of parents who abuse their children. That certainly happens.

But the type of child abuse that I find more insidious is the practice by some of the people that you might even go to about child abuse. It's practiced by the well-dressed, the well-degreed, the educated people, the Ph. D's—her mother didn't type up perhaps how she was going to abandon her and stuff and get tax moneys for doing so—what I see out here is professionals who actually type up their abuse under a rash of terms that are called therapeutic modalities, milieus, rage reduction, time out instead of saying we are going to lock the kid in the room. Now, if her mother went and tried to justify to the "authorities" that this is a cruel thing to do to abandon her, hopefully she would be locked out of the room. Sadly, when professionals look pretty good, and if all have their degrees, particularly if it's typed with a nice glossy cover on it, yet listened by, sadly, or maybe even some of yourselves—I know I listened to them—they are not parents practicing something at the height of anger, but it's more insidious by virtue of the fact that they have a bag of tricks, like I say, where they call it every other thing than what it is.

I know my own child was in a private school—by the way, no one has a monopoly on this type of abuse—it happens all over the place—when he was younger, I mentioned that he was autistic, he is brain damaged, he is not normal and probably never will be. I took him to see *Pinocchio a couple of weeks ago. That was a feat in itself* because he doesn't understand the dialog until the part where they put Pinocchio in a cage, and he started screaming just as he does when he sees any cartoon where somebody is put inside something and the door closed. So I had to exit the movie for something that happened as a "therapy" from the professionals that practice it out there.

I have often felt through the years with Robbie that where I was not fully informed—by that I mean not using the cheap, glossed-over technique of exactly what people meant, that he was abused. Because he was autistic, the thinking at the time and still in some circles today is that an autistic child is caused by parents who are cold and professional and not very specific about how you screw them up other than that—the idea was that the parents didn't relate in a nurturing way to the child whereby causing the autisism. So if you are a parent out there of certain handicaps and you are trying to ward off abuse, if you are looked on as a villain, you don't get a lot of attention paid to you.

I live in an area, San Jose State, where they employ a psychologist who teach a process called rage reduction or Z-Process. Thankfully, he lost his license to practice psychology by use of this method. What it is is an intensive—it can last as much as 13 hours—of rage reduction where he and his students and therapists hold a person down for many hours, tickling them unmercifully trying to induce a rage. I was very upset in my school district, because we can all chalk that up to some funny psychologist doing this funny thing, my school district, when it came time to enroll Robbie into special classes, had a little thank you, an acknowledgment to him thanking him for his technique and that they were using a modified version of it. With compulsory education as a parent, I am scared. I don't have the option of keeping my kids at home. I know parents who do keep their kids at home and obviously won't tell anybody their names. They are not keeping their kids at home because they don't like the curtains in the classroom. They are scared for their children. There's a terrible false assumption that people in the mental health profession know what they are doing, and this spills over into education. Many of their techniques are devised in the mental health field, and they spill over into the educational field, and so neither of them know what they are doing. Because of recent laws, and some of them are very good, there's a whole population of children out here now in the school who nobody knows what to do with. Nobody even knows what it is. I can say my child is autistic. He acts very abnormally. It's very difficult for him to understand words unless they are extremely concrete.

There's an awful assumption that if we get to the right degreed person that somehow help will be on its way, and I have found that these are the very people who come up with the funniest, weirdest, cruelest therapies, and I think that we have to accept that and not say, hey, this mental health field is all about these types of problems and everybody knows what to do about them. All the people I'm talking about, whether they're Ph. D's, they're degrees, they're everything else, they use bigger words in glossing over their abuse, but it's the same type of thing.

I would like to go into some of the therapies—I even hate the word "therapy"—that some of these kids get not by angered parents, by professionals. These are usually people from the "Behavior Mod Squad." I am not saying that all behaviorists are bad people. They have, in public schools, they have force-fed children. There are public schools that tie children to a chair. Some of them are tied to the chair for the learning center part. Some of them are tied to the chair and have to walk from this learning center [indicating] to that with the chair on them; and the world will say, "Doesn't the parent know about this?" or blah, blah, blah. Legally, everyone covers their can and has the parent sometimes sign a statement saying that they are using some types of techniques. Again, they use words like intervention techniques, modalities—they are all glossed over so the parent isn't fully informed about what these techniques are. I think that would be a partial solution.

The second solution is by and large the children that get the most abused are the most handicapped. They can't run home and say, "Mommy, I was locked up today," or say, "Mommy, they force-fed me today," or "Mommy, they took my lunch." Many of them can't talk, and those with a little bit of language can't communicate too well.

With my own son, he can come off the schoolbus not saying I got locked up today. I find out that he hears the words "time out" at a football game. He will say, "No; but you're not locked up." That's how I find out.

I think there should be a law against using certain educational jargon, psychological jargon, in telling parents what people do with their children, No. 1. It has much more impact if you say, "Oh, we locked them up for an hour, 5 minutes, 3 hours," whatever.

The second thing is because these kids are the most vulnerable and the most handicapped, many of them can't tell on the therapist. Parents, even if they are told that they are doing some things to their children, it's told with that there's no alternative. These are the kids that have been kicked out of every place. I think parents should be told, hey, you do have an alternative, if you find a private school out there or another class out there that takes these children and don't find a need to use such aversive techniques—you know, you get carte blanche to use that—parents are not told that. The few times when they are told about using aversive techniques, it is always under the guise of like, hey, take it or leave it or your kid's out—and I think my 3 minutes might be up.

Thank you.

Senator **Cranston**. I would like to ask you a couple of questions. What percentage of parents of handicapped children do make an effort to follow what is happening to the children in residential facilities?

Mr. **Hopkins**. I can't give you the definite number. All I know is that in meetings with parents, which is very often in given organizations that I belong to, there is a feeling that they have—they certainly will talk to each other, but a large percentage, for instance, I have some parents who are hiding with the kids out at home, knowing that they are committing—I don't know what it is called—for keeping the child out of school. A thing that stops some of them, but not all of them, is when you do go and ask, you are considered a hostile parent and uncooperative. For instance, I am considered a hostile and uncooperative parent, not by the school that my child presently is in, but all through my records, I couldn't believe—rather than getting gold stars for looking into what was happening to him, it's a very sick, sick thing. They will portray the parents as being overly protective or causing a problem, and if you would listen to them, it's turned against you.

Senator CRANSTON. Is there also a fear on the part of parents that maybe the child would be removed from the institution and no alternative exists?

Ms. HOPKINS. Definitely, and that's a very valid and justified fear. That fear didn't come out of the sky because I know that that has happened. I had a parent tell me when she knew about these hearings that she was told by her school if she didn't back down her kid would be out, and this isn't like off-the-wall schools. This is it. This is what's out there. These aren't funny little therapy classes.

Senator CRANSTON. Thank you very much.

Ms. HOPKINS. You're welcome.

[The prepared statement of Ms. Hopkins follows:]

Ms. **Kaplan**. Senator Cranston, I spent 7 years teaching handicapped children before I went for my doctorate, and I have to totally back you, first of all, and agree with you about your feelings about professionals. Hopefully, I'm trying to get cured.

One of the things I really remember is one day a parent looking across a table and a psychiatrist who was on our team saying, "Hey. I want you to remember something right now, all of you choose to do what you are doing, went to school for 4 years, for 8 years, for 10 years, for 12 years, to work with these kids." I woke up one morning, went to the hospital, had a baby and was told within 1 second that I had to accept the fact for the rest of my life I was the parent of a handicapped kid. Don't tell me what I'm doing wrong. When the tables turned on me and after my son had never been to school and, you know, his whole life, and I finally put him in fifth grade—and he's in a foster home—in November I legally got him in court; and 4 days later, it's time for a parent conference. Phyllis Kaplan instead of Dr. Kaplan is called into the conference and told that she has a very insecure child, that he should not be living with a white mother because he is black, that whatever I have done to him through the years—for 4 days I had him—has totally damaged him.

I totally sympathize with the facts that the schools have also in a way set up a system which does not allow parents to say, you know, I don't like what's going on, because the alternative is my kid is going to get sent to Napa, my kid is going to get sent far away; and I have to really take my hat off to the parents who have kept kids at home. In Denmark where I have worked, if you keep a child at home, the Government helps you keep that child home. You get extra money because babysitters are more costly. In this country, if you keep a child at home, you get punished for it.

Senator **Cranston**. Thank you.

Ms. **Jolly** K. Senator Cranston, if we are finished with our testimony, is it all right to——

Senator **Cranston**. Certainly. You are not captive here.

Ms. **Jolly** K. Thank you.

Senator **Cranston**. Who's going next?

Ms. **Gresher**. Good morning.

My name is Kathleen Gresher. I have worked for 4 years for an agency in this area which I will name, and that's Catholic Social Services, and as far as I am concerned, their child care is some of the best going, and, you know, it's just excellent. By way of background—for the most part—however, there do exist these type of abuses which I would like to address myself to, however subtle they may be or seem. The end points of them can be just as dangerous, as I will point out in my testimony, as if you were beating the child yourself, and that's the point that I would like to address myself to as these other women have done.

At any rate, I have worked as a counselor for Catholic Social Services for 4 years between the years of 1973–77.

Senator **Cranston**. Would you move the mike up closer?

Ms. **Gresher**. OK, did everybody here hear what I said?

OK, my name is Kathleen Gresher. I want to address myself today to the subtle abuses that are found in one of what I think is one of the best child care agencies that I have seen in the 10 years that I have worked in child care in this area and in the Middlewest, and the points that I would like to make relate to the type of abuse which the woman next to me was addressing herself to.

When I first went to work for this agency almost 5 years ago, I was just amazed at the physical comforts that the children had. I, myself, was brought up in a very poor, a nonworking working class family up in northern Wisconsin; and at the time that I started working, I commented to my husband that at several points I wished that I had been placed as a child, as a teenager, in an agency because the children just had a lot more to go on, a lot more physical comfort which is very important. However, the subtle abuses, which there is little or nothing to do about, if you are a counselor and you report on some of these, you just feel, as these other people have said, that the child will be "sent out", something else will happen to him, something worse, so, therefore, it's a losing proposition.

I also worked with Congressman Ronald V. Dellums as a prison case worker. I have worked there for 4 years, and I know something about the end points of these kind of covert as well as subtle and hidden abuses, and that is why I brought myself to this committee meeting today.

One of the most troubling experiences that I have had in child care had to do with extremely poor sex counseling on the part of one of my superiors, in my opinion. One of the boys in the adolescent male group home that I worked in appeared to be developing a homosexual tendency, or, at any rate, he was exploring his own orientation and he wasn't sure of which way he was going to go. Now, it was suspected by some of the workers in the agencies that this youth had already had several dubious and possibly dangerous encounters. So the way this was dealt with—and I think that this would be difficult for a lot of people to believe—is that one of my supervisors gave one of the social workers the responsibility of interviewing the "friends" of this young man who was at the time 14 years old, and many of these friends were 20—it says in the copy that I submitted 10 years—but I forgot how old he was at the time. He was 14 years old, and several of the men that I remember having been interviewed were between 30 and 40, 34 or 35; and, at any rate, these people were interviewed, and the purpose of the interview was to ascertain whether or not their intentions were "honorable", "honorable and serious"; and when one of this—I questioned that, and as near as I could come to an answer was that meant that it was not going to be a one-night stand.

So when one of the friends passed the screening process, it was not uncommon for the young man questioned to be given permission to spend the night, and often the weekends, away from the group home and out of town with the fellow; and I once commented to my supervisor that if I were to interview the friends of the girls in the adolescent female group home, interviews to ascertain if their intentions were serious, and then give them permission to go away with these fellows for weekends, he would think that I were grossly negligent; but comments in that were dead seriousness—and nothing happened, there were no correctives given; and I was just scared to death, as I was most of the time, that I ever address myself to any of these subtle abuses or indiscretions that the kid would end up in juvenile hall, which, of course, they all hated and was the place that they almost always did if there was some question about their institutional care.

Two other areas of concern to me, particularly in dealing with the females, was the rampant venereal disease and prostitution in the group home setting. Due to a combination of improper personal hygiene and a lack of discrimination in choosing male partners, many of the adolescent girls suffered from venereal infections. The infections were usually discovered and treated only after they had reached an acute stage; and even after such treatment, there was virtually no counseling in feminine hygiene, and a lot of the girls would be reinfected within a few weeks' time.

The promiscuity and disease, I believe, is related to, this agency as well as almost every other agency I have ever worked in, failure to encourage outside interests on the part of the girls and any real attempts, any concentrated attempts and any channeled attempts at trying to get them to develop outside interests rather than engaging in traditional and deficient female practices of getting, having, and holding onto a man.

During the time that I worked in this agency, one of the girls that I worked with was raped and murdered by her boyfriend in Golden Gate Park. Another one had the sad experience of having her boyfriend murder his other girlfriend, and most of the relationships that they had were very unwholesome, and they were, you know, just basically unaddressed.

I have been asked to conclude. I have several more points here, but I thank you for your time.

Senator CRANSTON. Thank you very much.

The balance of your statement will go in the record.

[The prepared statement of Ms. Gresher follows:]

Senator **Cranston**. Ms. White you may proceed.

Ms. **White**. My name is Marie White. I'm with Citizen Advocates of Northern California, which is, for the large part, a lay group of persons.

I am myself the parent of a handicapped child, and I have also been a professional social worker.

I am reminded after listening to the other panelists this morning of just a couple of experiences which I will tell about before I go on to my prepared statement because I know the time is very short, and I do want to share with you what I have.

Christmas Day I decided to go visit a youngster that I was aware of who had been in Dependent Children's Hall in Stockton for 3 months. I called a couple of days beforehand and was told yes, he was still there. So Christmas Day I took off in the fog and went to deliver a Christmas present only to find that he had been shipped to San Bernardino County. This is a child who has been shipped literally everywhere.

Also, this past week, I as a professional worker, tried to make arrangements for a boy 13½ years of age, to be placed pretty close to his sisters so that they would be able to have some mutual support from each other, only to find that the foster parents who had the two sisters had, without so much as a bye or leave, gotten up in July and moved to another county and had simply failed to advise anybody, and these are very typical situations about shipment of children much as if they were pieces of furniture.

The foster care industry costs the taxpayers of the United States $1.2 billion a year, and that's the foster care situation alone.

Additionally, Federal, State, and local taxes support mental health developmental disabilities and other out-of-home placements. California alone has 4,000 children in its State hospitals and several thousands more are with the California Youth Authority or in receiving homes, juvenile halls, or camps run by local authorities.

When I look at our State plan for social services, I can find out that we have 49,866 children who are expected to go through the AFDC out-of-home placement situation this year. At any given time, we have at least 30,000 children. So we're talking about lots of movement there. When you add up all the other kinds of placements that are involved, we probably have over 70,000 children in the system in a year's time in California.

Senator **Cranston**. How many, seventy what?

Ms. **White**. Over 70,000 children at various times, out-of-home placements.

California has received $55 million in title XX in social service funds ostensibly to provide social services to children. Yet foster care and out-of-home placements have become a garbage pile of our civilization.

Once the child gets into the out-of-home system, the child is swallowed, sucked into the maw of a brutal indifference, helpless, mostly unseen and without recourse. In our murderous ineptitude, we allow children to be removed from families and scattered we know not where. Nearly one third of the children entering the system become lost. How many foster care children, wards of the State, died at Jonestown? We just don't know. We don't know. Not yet, and some of us intend to find out. That we don't know is an indictment of the system itself.

In the name of behavioral science, we allow children to be subjected to torture. Dr. Mathew Israel, a psychologist, operates Behavior Research Institute in Rhode Island and works with Behavior Research Institute of California in Northridge, Los Angeles County, where at rates over $30,000 per child, Dr. Israel is blessed with $1,368,769 a year for 43 autistic children from New York, New Jersey, Massachusetts, Wyoming, and Los Angeles, on whom he practices "aversive therapy" which is so punishing that one child at the Los Angeles facility was left with blistered feet and bruised black and blue making it impossible to walk.

The picture darkens; where once neglect caused most abuse, nowadays abuse comes in the name of therapy. Sadistic sequences of consequences have become the lot of handicapped and worried children and youth. A look at the last 10 years shows us where we have come. It does not tell us when the brutality and abuse will stop. At this time abuse is highly paid for with public funds.

In 1968, in Amador County, a probation officer reported on the last days of a 6-year-old retarded boy's life. Kevin had been living in a State-licensed facility for handicapped children. The probation report reads:

"Dr. stated: 106 degree temperature; dehydrated; dermatitus of mouth and nose; possible 3d-degree burns; lenial gash under chin; lump behind right ear; pictures show sores on mouth, chin, nose, ears, arms, legs, back; gash under left arm; black and blue buttocks, legs, arms, wrists. Boy not expected to live through the night."

In fact, Kevin died 3 days later, and two different district attorneys tried to press charges and got nowhere. The State continued to license the facility, claiming that no statutes had been violated.

I personally had a child at Oak Creek Ranch from 1966 to 1969. For the entire 3 years, I reported conditions to the Golden Gate Regional Center to no avail. I found my son with human bite marks all over his arms and shoulders. I found him ill in bed, secured to the bed, without his having been seen by a doctor. I found him with the tip of his thumb sliced off by the door which later featured in the death of another child. A door which caused the operator to laugh at him, because once the children shut the door, as they properly should do, they could not get back inside again.

The Golden Gate Regional Center agreed that my complaints were justified and put that in case records, as if writing was the same as doing. Nothing happened and children continued to be misused and abused.

My son was removed to another place of abuse. Two years after my son left Oak Creek Ranch, Euguene Smith, age 15, was found dead outside the sliding glass backdoor. It was 6 in the evening when he was found. It was very dark and raining heavily. When discovered, the body was clad only in white sweat socks, a pair of tennis shoes, and a green T-shirt. The coroner noted, "Extensive evidence of trauma, cause of death undetermined." A telephone call went from Sacramento headquarters to the Berkeley licensing office instructing that the death was to be kept quiet because of the effect it might have on the hospital depopulation program and community placement. Marjorie B. Edelson, a State employee, sent a memo to her boss on January 2, 1972, stating that she had visited Oak Creek Ranch about, quote, "The death on December? (Sorry, actual date escapes me) of Patient Eugene Smith, 15." A child died and the worker couldn't even trouble to supply the date. Ms. Edelson concluded her memo with a statement that the Guidottis, who ran Oak Creek, have been licensed since January 14, 1964, and have been regarded as operators of excellent programs for disturbed, retarded boys.

I think we all know the history of Oak Creek Ranch. It was subsequently closed. It was 10 years since the day that I first had reported what was happening to my son at that facility.

From 1969 onward, I made complaints to Golden Gate Regional Center and to the Santa Rosa licensing office about the place to which my son was transferred—Aycock Ranch in Sonoma County. I raised hell for 7 years, and all public officials involved turned a deaf ear. Placing agency, licensing agency, assemblymen, Senators, all turned off.

The first year my son was at Aycock's, I found him with an 1½-inch laceration on his scalp, the edges bloody and congealing. I pointed it out, asked that medical attention be given, and I asked questions. I received no answers. A month later, the wound was still untreated, only now it had become a suppurating mass the size of a goose egg and smelled badly. I took my son out to a relative and undressed him to bathe. I found his body covered with bruises in lines all across his back and shoulders. I took him to a clinic in San Francisco. I reported again to the placing agency, Golden Gate Regional Center. Still nothing happened. I pressured Mr. Aycock, and he then stated that he had just fired somebody for whipping the boys down at the little building. Licensing records show that former employees filed complaints against Aycock with the Santa Rosa licensing office claiming that Mr. Aycock himself beat a child. Nothing happened. When I complained of lack of medical attention to Dr. Rhona Rudolf of the Golden Gate Regional Center, she said, "Well, they don't even believe in it for themselves."

Time went by. I saw a child slapped. The conditions were very crude. The garbage cans spilled over. Horse dung was in the playground, manure and flies everywhere. I saw another child, Todd Berry, dragged along the ground about 15 feet by a male, 6-foot child care worker and was told by a woman staff member, "I am glad we have guys to keep Todd in order. We are getting rid of him. He's a nuisance. He is going to be sent elsewhere."

While my son was at Aycock's, there was a 9-month period when he was sent to Grace Reece Development Center during the daytime hours. This is a program in Sonoma County School District. When I finally got a regional center counselor to escort me to the Grace Reece Center, she finally saw what I had been telling her. My son was tied to a chair and left alone in the middle of the playground. The principal/teacher, Ms. Joyce Eckram, is now with the State Department of Education in Sacramento. She is going to tell other folks how to do it.

While I was experiencing Aycock Ranch, autistic children in Fresno were getting the treatment at Kate Schools from 1972 onwards, and one of their advocates reported that to the attorney general's office, but it continued. In 1972 Norman Wilson used an electric cattle prod until stopped. Then he had to content himself with pinching, slapping, jabbing pencils between fingers, cold showers, confinement to cubicles or closets, flicking, withholding foods, paddles, force feeding and pinching of testicles.

Also, during this time in San Diego at the Schowers Schools, things were very bad. In December of 1972, a 12-year-old, mentally-retarded boy was subjected to the attacks of older residents—a 6-inch rusty nail was inserted in his rectum. He was stabbed and his penis amputated. Another boy fled in handcuffs and was found 2 days later walking a country road. For 10 months thereafter, other boys fled the facility and foraged the countryside for foods, stole automobiles for escape. Inrcedibly, when the license was revoked, the revocation was stayed to enable the place to continue in business.

At Ramona in San Diego County, I went to look up Mountain View School and Mountain View West where they practiced behavior modification during 1973–75—haven't gotten back to check on them lately—but during those times, one child had a trash can placed over his head and was put in the corner for a week. One had his hands taped together, and children were ordered to run until they dropped. Children were confined to their rooms for long periods of time or were put on the pole outside in the sun where the temperatures soared into the nineties and higher for indefinite periods of time.

The threat has always been—we'll send you to a State hospital—if you think this is bad, and then there's references to some other place. Unfortunately, there usually are places that are even worse.

Frankie, a teenager, died at Sonoma State Hospital in 1973. The death was brushed off as an accident—a locker fell on him, they stated. A State attorney general's report which stated that Frankie was struck at least two severe blows by another patient was concealed. Several years later, as a result of advocacy group pressure, the truth came out. Frankie was bludgeoned to death by a baseball bat wielded by another patient known to be violent; but all of this took place while the staff was having a party. The bloody baseball bat was then concealed. When the truth was forced out, it was then also discovered that the program director, Peggy Blair, had also concealed over 400 special incident reports. She was fired; but when she appealed, she was reinstated because, "What she had done was for the good of the hospital." The records from our State hospitals in California are not worth the paper they are written on. They are fabrications just as much as the works of Hans Christian Anderson, but there is nothing to delight us in them. They conceal the truth and hide abuse.

Stockton State Hospital, during 1973 and 1974, was in a shocking condition, awash in the patient's own urine, understaffed and abusive of its patients. While in Sacramento bringing the situation to the attention of the California Association for Retarded, our Citizen's Group found the news breaking about a child who had been beaten black and blue. After much publicity and investigation, work by advocates, it was generally agreed that conditions were bad and the hospital director was removed. However, when the Investigation of State Hospital Deaths was concluded in June of 1978, Stockton State Hospital was made to look like an expensive health spa.

In 1976 in San Joaquin County, April, a 16-year-old, mentally-retarded girl was found dead in a trailer that was a State-licensed community care facility. Four other children were placed there which made a total of nine people living in the trailer. The operator, a man, was found dead by suicide behind a shed. The autopsy report for April read, "Dead at the hands of another." That was 3 months after licensing officials had written into their records of the unstable conditions at the home.

Also, in 1976, our citizen's group found four mentally-retarded youths living in a garage in a State-licensed facility in Butte County. Conditions are often abusive in themselves.

In Stanislaus County, in 1978, Tuolumne River Rest Home in Modesto housed both aged and developmentally disabled residents. Records indicate that,

> * * * residents have been struck, bit, tripped, kicked, shoved, and burned. Known injuries suffered by residents include: fractured orbit of the skull, back bruises, jay bruises, broken nose, injured knee, and split lip. The number and seriousness of injuries incurred indicate lack of appropriate supervision.

After the licensing staff made their report and called a conference with Tuolumne River owners, a letter was sent by Dennis E. Pankratz, supervising counselor for Valley Mountain Regional Center, a State-funded agency, stating:

> Valley Mountain Regional Center is satisfied with the care that our clients have been receiving in the home.

Mr. Pankratz went on to identify one client which licensing staff had referred to as an "inappropriate placement," saying, "I personally placed that client."

It was Mr. Dennis Pankratz who went to look at Aycock Ranch in May of 1975 when he was director of Sonoma County Citizen Advocacy. Mr. Pankratz went at the request of Dr. Richard Koch, then head of community services of the State Department of Health, after I had been raising hell. In his letter to Dr. Koch, Mr. Pankratz states that he spent 1 hour at the facility—1 hour—then went on to say that his agency had had an ongoing commitment at Aycock and that the coordinator for his agency, Mr. Al Zonca, had formerly worked at Aycock. Other than that, it was rather a nonletter that had nothing to report on what was going on there. Rather largely the State and counties rapidly internalize the dissent which might accrue—it is very easily done with grants and jobs—sometimes something so cheap as allowing the use of a postage meter, as is done with parent groups at State hospitals.

In 1978, in Sacramento County came the end of the long saga of the Koehler facilities. Shortly after 4 a.m. on February 24, 1978, fire swept through the home for autistic children burning two of the children on the premises to death. The facility had no license to operate, and the State knew it and had failed to act despite the evidence which had been accumulating over the years since 1973. The final downward spiral for the Koehler facilities came when Patricia Koehler, the operator on the other Koehler licenses, met up with a parolee from the Nevada

State Penitentiary, Michael Sims. Ms. Koehler hired him; and then when he was arrested for oral copulation with a minor in Marin County, Ms. Koehler took out a bond on one of the properties to raise collateral for the bailment. Subsequent investigation showed that the facilities which were licensed for 12 children supposedly spent $58,000 per year on food. On the night of the fire, the house without a license had 20 occupants. Accounts following the fire documented the free-floating lifestyle and the free-floating money policies where child care reimbursement ran over $25,000 per child per year in public money.

Senator **Cranston**. Ms. White, I think I am going to have to ask you if I could interrupt you at this point. There's a couple of questions I want to ask this panel. You are giving us some exceedingly helpful and shocking information on some instances of abuse with tragic consequences. The entire document will go in the record—and I'm familiar with the balance of it already. I would like to ask if you can stop now so I can pose a couple of questions to this panel and then get on to the other people that are going to testify. You have been very, very helpful and I appreciate it, and the detail you are giving us is the sort of information that we need for our record if we are going to deal with these problems.

We will insert your complete statement in the record.

[The prepared statement of Ms. White follows:]

Senator **Cranston**. One question I want to ask you, Ms. White, or any one of you who feels like responding, or if you wish to comment on the first response, please do so—what role do you think is appropriate for the Federal Government to play in monitoring the quality of care that children receive in facilities juxtaposed to whatever role is going to be played by State or local agencies?

Ms. **White**. I believe there is a strong role in the enforcement in the purchase of service, first of all, the quality of the purchase of service. I'm aware of the audits which have been done by HEW Audit Bureau, but I am not aware of anything which has happened as a result. Some excellent audits have been done by that Bureau, but I think the workers are also very frustrated because they see their work coming to nothing. So I think enforcement from the Federal Government is essential, even if it means withdrawing funds. This is always a threat, and so far I have yet to see it done and, quite frankly, I don't believe the State of California is going to clean up its act until there is an actual withdrawal of funds with the condition you put it in shape or you will not get the money back.

Senator **Cranston**. I asked a question a bit back about whether parents were afraid to complain because their children might be withdrawn from the facility with no alternative facility available. Is there also a situation where people working in an institution, where there are abuses, are afraid to come forward and talk about it for fear that they will lose their jobs or suffer retaliation in some other way?

Ms. **White**. This is definitely the case.

Senator **Cranston**. And should we find a way to try to protect people?

Ms. **White**. Yes; we should. We need an agency to which persons within the system could take their complaints and have it investigated while they are not exposed.

Ms. **Kaplan**. I also think, Senator Cranston, that we have a problem with the fact that many institutions, for example, when Oak Creek Ranch was closed, we literally had kids coming out of the woodwork that would work there for 2 weeks, 4 weeks. So many institutions hire people off the streets, untrained, very quickly. They stay for 3 weeks, 3 months, they can't stand it, they leave, and they don't feel they have the power to go to anyone. I mean, when you stop and think of the Consumer Fraud Division which takes care of someone who goes to get, you know, a radio and it doesn't work or something, also took care of *Oak Creek Ranch's* court case, it's pretty shocking.

I think a lot of the people don't feel even that they know where to go to get help. There's got to be maybe some public statements on television. If you're working in an institution, if you know about abuse going on in the school, come to us, we will protect your name. It's got to get down to people who are not professionals.

Senator **Cranston**. I want to state right now to anyone whose ears might be reached by this, with the help of you and others, that we welcome and solicit any information that any parent or any employee or anyone else can give us about situations in institutions that we should be aware of where we may then be able to help. We will do our best to protect the name of such an individual, if they don't want it to be known.

Ms. **Hopkins.** I was just going to say, for those types of people, like when you said what can you do about employees who might be afraid, I can't stress enough some of the employees are part of the problem, No. 1. No. 2, you go for the big things. You go for the locking them up and that type of thing. There are types of abuse which are so widely accepted that even the workers don't call them abuse.

Senator **Cranston.** I understand that, and I appreciate your efforts to provide us insight into those.

Ms. **Hopkins.** The other thing that to me the Federal Government can do is under Public Law 94–142, that is probably the parents' only vehicle to have not just input but under services which were mandated in Public Law 94–142 for all handicapped children, a service, for instance, could be that all behavior-shaping techniques will have prior parental consent on a case to case basis and that they would have to be spelled out without using their psychological book stuff.

The way the Federal Government could help out, the Department of Education, nobody is afraid of anybody, that's the problem. The districts aren't afraid of the Department of Education, the Department of Education is not afraid of God, nothing happens to them. I think if the Federal Government, when parents file a noncompliance, which they are, they shouldn't play the game of, gee, that's too bad to do away with the program. A bad program is worse than no program at all. I would rather cut it all off.

Senator **Cranston.** Thank you very much.

Ms. **White.** Just one more thing. I think you're going to find that the reason that out-of-home programs have spread and proliferated, and they have, because once upon a time children would have been at home, is because the way we invest the money in our society. Child-out-of-home placement is big business. I have files that I have been collecting for 18 years. They're at the disposal of this committee.

Senator **Cranston.** Thank you. We do want access to that. Please talk to Susanne Martinez about it. That would be very helpful to us.

Did you have one more comment you wanted to make?

Ms. **Gresher.** I just wanted to comment on the fact which I had originally included in my statement that there's no consciousness, for the most part, in these institutions on the part of the staff or the people who run the institutions that they're working, in effect, for the parents when they're dealing with dependent children and that really isolates the staff in terms of these people we're talking about, subtle abuses. Generally the staff thinks of it as being an us and them proposition. The child is in the institution and the staff is responsible to that institution and the parent is the enemy almost. So no communication.

Senator **Cranston.** Yes.

Ms. **Hopkins.** May I just say one more thing?

Senator **Cranston** Yes.

Ms. **Hopkins.** Another thing the Federal Government could do is when appropriation comes for mental health money, there is an assumption that the more money you pile into something, the better it's going to become and in mental health education, that's not necessarily true.

Senator **Cranston**. That assumption is no longer assumed.

Ms. **Kaplan**. I would just like to share one last thing, Senator Cranston. That's when Mr. Banknicholson was here visiting with our ex-Gov. Ronald Reagan, there was a lot of publicity in the newspapers because he was asked what he thought of our facilities. He said we take better care of our cattle in Denver, and I'm sure that you've seen some of the publicity. We have surges where all of a sudden the newspapers are filled for 2 or 3 days, or something else is happening, like one of these institutions is being closed. Then it's forgotten. I guess what I'm asking you is can you please do something about getting the awareness up even if it means continual bashing of the television that we need help.

Senator **Cranston**. I assure you we'll keep at it. As far as I'm concerned, I'll keep at it until there's a remedy as long as I'm in a position to do something about it.

Ms. **Kaplan**. Thank you. I would like to say that a few years ago a student of mine handed in a lengthy paper, which I will mail to you, that suggested that all retarded children be sold as pets when they were born because their institutions have been really, in essence, no different than pet stores, and it went on and on for five pages and at the end, there's this horrible thing about how the retarded are easier to train than dogs and would be able to eat the scraps off the table and you wouldn't have to go buy special food, it gets even more descriptive, it was a disgusting paper. And it ended with, "if you think my idea is not a sound one, ask, the retarded themselves whether they would have not preferred to be sold as a pet to a beloved family at first than to have endured the pain they have since gone through."

Ms. **Hopkins**. Ms. White told us about the place in Los Angeles, I would rather my child in a place that didn't have the money to torture the kids.

Senator **Cranston**. I want to thank you, and the two who had to leave, very much. You've set the stage for some very important work and you've set the tone of what we are seeking to understand and then to deal with it. You have been most helpful and I thank you.

We're now going to take about a 2-minute recess and then proceed with the next panel.

[There followed a short recess.]

Senator **Cranston**. The hearing will now resume.

We'll proceed with panel No. 2. If you would each introduce yourselves as you speak, I would appreciate it very much.

Thank you for being with us.

STATEMENTS OF ABIGAIL ENGLISH, NATIONAL CENTER FOR YOUTH LAW, ACCOMPANIED BY ROBERT WALKER, PETER SANDMANN, AND PETER BULL, A PANEL

Ms. **English**. Thank you, Senator Cranston, for the opportunity to present this testimony.

My name is Abigail English, and I'm a staff attorney for the National Center for Youth Law here in San Francisco. The center, as you may know, is funded by the Legal Services Corporation to engage in a variety of forms of legal advocacy on behalf of young people throughout the country and to provide legal assistance to legal services attorneys in their attempts to secure and expand the rights of children and youth.

My colleagues and I will each address one of several aspects of the institutional abuses to which children are subject, and each of us will speak about an area with which we're particularly familiar and respond to questions in that area if you have any.

I would like to begin by briefly addressing some of the abuses to which foster children are subject in the foster care system. There are, in my mind, two broad categories of abuses, one being the specific physical abuse and neglect to which individual children may be subjected in foster homes, group homes, or institutional foster care placements, and the other are the more general systemic problems which many of the thousands of foster children suffer from.

I will use the approach of telling you about three cases, very briefly, which our office has been involved in or which have been brought by other legal services attorneys on behalf of foster children. I believe that each of these three cases illustrates quite dramatically some of the most serious forms of institutional abuse which foster children suffer from.

The first of the three cases is called *Smith* v. *Alameda County Social Services Agency*, and was brought on behalf of a 17-year-old boy who had been in foster care his entire life. He was relinquished at birth for adoption. He was never adopted. He was under the care of the County Social Services Agency and was placed by that agency in a series of 14 different foster placements. In at least one, and probably several more of those placements, he was physically abused by other foster children and was subjected to sexual assaults and other forms of humiliating treatment.

He attempted to contact his social workers on a number of occasions to complain about the treatment he was receiving and to express his desire to be adopted permanently by a family of his own. None of these attempts were successful in the sense that none of them resulted in his being adopted. And it was only after he wrote letters to various public officials, including the Governor of the State, asking to be removed from some of these more difficult and unpleasant placements, that any action was taken on his behalf.

I think that this case raises the issue of the multiple placements which many foster children suffer from. The most recent report by the State Department of Health in California, which came out in 1978, in January, shows that 57 percent of foster children are in more than one placement during any given year. This case also raises the issues of——

Senator CRANSTON. In any one year?

Ms. ENGLISH. In any one year or in the most recent year that was reviewed, 1976–77.

Many foster children who could be adopted, who are of adoptable age, or who are free for adoption, are not adopted, as you well know. The statistics from California, based on a sample of 463 cases, demonstrate that in only 8 percent of those cases was adoption the case goal. And that for over 60 percent of the cases, permanent foster care or no case plan at all was the recorded case goal.

In addition, I think that the *Smith* case illustrates the specific kinds of physical abuse that certain foster children suffer from in foster homes and the fact that social workers are either unwilling or unable to respond to those kinds of problems, are sometimes unaware of them because of excessive caseloads and sometimes inactive in response to them because of excessive caseloads, and often simply unwilling to take any action or have no other place to put the child or don't believe the child's complaints. This is exacerbated by the fact that many foster children are assigned a whole series of caseworkers and, for example, in the same State Department of Health report here in California, it appears that 77 percent of the children in the cases reviewed were assigned two or more workers during their foster care placements, and close to 30 percent of them were assigned two or more workers in the course of 1 year.

The other case that I would like to mention briefly is the case of *Bradford* v. *Davis*, which is a case that is now pending in the State of Oregon. The plaintiff in that case is also a 17-year-old boy. He has been in foster care, either a foster home or institution, since he was relinquished for adoption at age 8. He has not been adopted. He has been in several foster homes and is currently in a State training school.

In his first foster placement he was subjected to beatings, forced to eat pepper, was abandoned over the weekend, locked into the house when the foster family went away; he and his sister were locked in the basement, and there is a long list of other abuses to which he was subjected in that home. While he was in that placement, no social worker visited the home or contacted the home for a period of 3 years. When a social worker finally did visit the home, the foster mother sent the boy out to the park and would not let him speak to the worker.

Senator CRANSTON. Do you feel that budget problems are part of the difficulty? I know there are many other difficulties, but is there inadequate funding so there are not enough people to make decent checks given the workload?

Ms. ENGLISH. In some instances, it's a question of inadequate funding. In many instances, it's a question of misallocation of funding, excessive funds going to administrative costs rather than direct service delivery. I believe that excessive caseloads for social workers is a serious problem. The average in California for 1977 was 44 cases per worker. It would be very difficult for workers to abide by the regulation that they must visit each foster child under their care once a month for 44 cases.

The last case I mentioned, the *Bradford* v. *Davis* case, illustrates, I think, both the kinds of physical, direct physical abuses to which foster children are subjected, even in foster family homes, not only in institutional foster placements, and also illustrates the failure to find permanent placements and the problem of multiple placements.

The last case that I would like to mention very briefly was again one in California in which the plaintiff was a 2-year-old child who had been in foster care. He was born with cerebral palsy, was very rapidly removed from his natural family and ordered by the juvenile court into foster care. He was placed by the Social Service Agency in an unlicensed foster home despite the fact that his grandmother had sought to have custody of him and had expressed a willingness to care for him and the agency had visited the home and determined that it was an appropriate home and a fit place for the child. He was not placed with the grandmother but rather in an unlicensed facility where he suffered from malnourishment and dehydration, was underweight, was subsequently diagnosed as having a protein deficiency, had rashes and bruises on his body, and continual respiratory infections, including pneumonia; he was never given any medical care during the year and a half he was in that foster home. And these abuses were only discovered when his natural parents visited him and reported his condition to the sheriff. At no time during this year and a half did any of the agency personnel discover the deteriorating physical condition of this child, who they had reason to know, from the fact that he was suffering from cerebral palsy, might need serious medical attention. And they never determined whether he was receiving it or what his medical state was.

I think I'd like to stop now and let one of my colleagues address one of the other aspects of the problems of institutional abuse unless you have any specific questions you'd like to ask.

Senator CRANSTON. I'd like to ask you one question. I'd like to ask you to submit the answer in writing and give you more time to think about it. You're familiar with the legislation that passed the Senate and the House but didn't become enacted last year. I'd like to have your thoughts on how adequately it would deal with the problems we're focusing on today, abuse in institutions, and whether you think there are any changes needed in the legislation.

Ms. ENGLISH. I assume that you're referring to H.R. 7200.

Senator CRANSTON. Yes.

Ms. ENGLISH. Yes; I would be happy to submit that.

Senator CRANSTON. Thank you very much.

Mr. WALKER. Senator Cranston, my name is Robert Walker and I'm also an attorney at the National Center for Youth Law.

I'm going to address very briefly two areas. The first has to do with juvenile halls and second has to do with psychiatric hospitals.

Several years ago I and some of my colleagues became involved in a lawsuit concerning conditions in the juvenile hall in Yolo County, in Woodland, Calif. And I think that the conditions that we found there are somewhat illustrative of conditions you would find elsewhere in juvenile halls in rural counties.

I might point out the only reason we were able to gain access to this institution to discover some of these conditions was that a law student from the University of California at Davis happened to be writing a paper about the juvenile hall and contacted us because she was so concerned with conditions in that institution.

What I found were minors detained in rooms 8 feet long and 4⅔ feet wide. Despite the fact that there was a prohibition against placing more than one minor in a room, the hall was frequently overcrowed so that two children would be placed in such a room, thus making them much more vulnerable to physical or homosexual attacks. Minors were routinely isolated in the hall. Minors were only allowed to visit with their parents certain times of the week. If the parents worked, they couldn't see them at all. They were not allowed to visit with siblings. Communications, all letters minors wrote, even to their families, were censored; many of them were confiscated. Children were punished, and the most frequent form of punishment in this institution was lockup which meant being locked in your room for anywhere from 1 hour to 72 hours. We found that children were locked in the rooms for such things as a male child saying hello to a female child who was in the hall, a child shrugging his shoulders when told to do something. Children who were slow, who do not perform well in school, were punished by being locked in their rooms from 5 o'clock in the afternoon until the next morning.

When I was at the hall, I was physically present there, I observed one of the counselors ask a girl to leave the dayroom where the children play and she was rather slow in doing that; and the counselor took the girl's arm and twisted it behind her back and said that if she didn't move more quickly, she would be spending a lot more time in that institution.

One of the most alarming things, from my point of view, is the fact that children who enter the hall suffering from drug withdrawal were also isolated and expected to undergo their withdrawal without any medical care in total isolation. And I was distraught to learn several years after this litigation concluded that one of the children that was undergoing drug withdrawal and was isolated hung herself in her room and died as a result.

Ostensibly, the California Youth Authority has the responsibility for checking into conditions in these institutions. We found in the trial that went on in Yolo County that what the Youth Authority did was send one person to each institution for perhaps 1 day each year and 90 percent of that person's time was spent with the superintendent of the institution going over checklists of conditions and in asking, for example, is your institution overcrowded, and if the superintendent said no, they'd check it off. And he spent almost no time inspecting the facility.

I would like to just briefly read a paragraph from an affidavit because I think it reflects the attitude of one of the counselors who worked in the hall. This is an interview between the law student and a counselor, one of the counselors who was supposed to be treating and caring for these children. His name on Ron Gimmel and Mr. Gimmel says that, "isolation or lockup is used both as a punishment for physical aggression or noncooperation and also as a stimulus for behavior modification. For a 'slow child,' he sets out a specific behavior pattern and the child is locked up if he doesn't reach that pattern. Mr. Gimmel estimated that they 'the inmates' may spend 90 percent of their time watching television. As an explanation for this, he said that there isn't enough staff to occupy all the kids and he feels the kids aren't interested in doing things, he thinks they should also have to be creative. Formal visiting is restricted to 3 hours a week. According to Mr. Gimmel, there is no reason to allow parents more visiting as they've already messed up their children." And finally, Mr. Gimmel's main purpose is "* * * confining the kids. He feels he's paid a salary to confine the children."

I think this illustrates better than I could the attitude of, at least, some of the people who work in these institutions.

I'd like to also say that this is by no means limited to this institution. There have been in recent years, for example, a lawsuit in Los Angeles concerning vast overcrowding of juvenile halls in that county and, indeed, the evidence of the trial there indicated that to avoid the census that's taken every day to tell what the population of a hall was, the Los Angeles Juvenile Hall would ship its kids out, actually put them on buses, transfer them to other institutions or riding around the streets of Los Angeles so that the population statistics would not accurately indicate that these halls were overcrowded.

Second, I'd like to turn to the question of the psychiatric hospitals. I have many clients, for example, who have been in McAuley Neuropsychiatric Institute, which is part of St. Mary's Hospital in San Francisco. I found that uniformly those children are drugged to such a degree that they can hardly communicate with counsel, and in one case the child actually fell asleep during an interview with me.

In another institution, a private psychiatric hospital in San Francisco, even though the program had only been in existence for 18 months, there had been three succesful suicides in that 18-month period. My client who frequently threatened suicide was not taken seriously, and the only reason she finally was taken seriously was when she escaped and she was found trying to throw herself off the Richmond-San Rafael Bridge.

Finally, many of these children wind up in the State hospital system, such as Napa State Hospital. The difficulty up there is just enormous. I found that children are frequently inappropriately placed there. Two brief illustrations.

I had one client who was a black youth from San Francisco whose main problem was truancy from school. After over a year of doing legal battle to try to secure his release and being successful, the director of the adolescent treatment program told me that that child should never have been there in the first place. Of course, he didn't say that until after the child had been released.

Second, I was approached by the father of a young girl. The girl had been committed to the institution by her mother and the father thought that that was totally inappropriate inasmuch as the mother, in his opinion, was crazy and the girl was not. In fact, the mother herself had been hospitalized at Napa State Hospital previously for a 2-year period. When I went up to the hospital to inquire, the staff agreed that the girl shouldn't be there. But they said they didn't want to release her to her mother because they felt the mother was crazy. They didn't want to release her to her father because the father did not have legal custody. When I threatened to bring legal proceedings, again the girl was released.

Finally, as you probably are aware, there have been numerous reports about deaths in the State hospital in California. And it was reported approximately a year ago about a young adolescent girl that there had been a party that was given for all the children around Christmas time at Napa State Hospital, they were using a building that was not supposed to be used. The girl wandered off and she disappeared. The girl's family wanted to know where she was. The staff said they had looked for her and they assumed she had escaped. Finally, the girl's sister came, combed the grounds and found that the girl had fallen down a ravine and was killed. This is the girl's sister who had found this. The staff hadn't cared enough to determine what had happened to the girl. So there are enormous problems in the hospital system as well as in the juvenile hall system.

I believe that the next person who will speak will be Peter Sandmann.

Senator Cranston. Thank you.

[Information supplied for the record follows:]

Superior Court of the State of California for the County of Yolo
Juvenile Court

IN RE YOLO COUNTY JUVENILE HALL; NO. 5326, EX PARTE MOTION PURSUANT TO W & I CODE § 509

To: The Honorable Superior Court of Yolo County, Juvenile Court Department:

1. This motion is brought pursunt to W & I Code § 509 to close the Yolo County Juvenile Hall because said facility is an unsuitable place for the confinement of minors and/or for preliminary and permanent relief mandating that said Juvenile Hall shall be operated and maintained in accordance with the standards adopted by the California Youth Authority for the operation and maintenance of juvenile halls, and in accordance with all pertinent statutory and constitutional provisions.

2. This motion is brought by petitioners Donna C. , Arthur N. , Lorenza V. , Terry H. , Maggie G. , John F. , and Paul T. as a class action pursuant to Code of Civ. Proc. § 382 on their own behalf and on behalf of all other minors who at any given time are inmates of the Yolo County Juvenile Hall. Petitioners Donna C. , Arthur N. , Lorenza V. , and Terry H. are minors who are presently inmates of the Yolo County Juvenile Hall. Petitioner Maggie G. is a minor, a resident of Yolo County, and is attending school at Yolo County Juvenile Hall, Petitioners John F. , and Paul T. are minors, residents of Yolo County, have been confined at the Yolo County Juvenile Hall within the past week, and by reason of age, residency, and situation are subject to being again confined at Yolo County Juvenile Hall within the near future. The question presented by this motion, namely, the suitability of the Yolo County Juvenile Hall as a place of confinement for juveniles, is of common and general interest to all members of the class of persons petitioners represent. The issue presented is also of great public interest. Said class is so numerous and dynamic that joinder of all members is impracticable. The claims of petitioners are typical of the claims of their class, and petitioners will fairly and adequately protect the interests of their class.

3. The Yolo County Juvenile Hall is presently unsuitable for the confinement of minors because it is in violation of numerous standards contained in the Youth Authority's Guidelines for Inspecting Juvenile Halls (July, 1969) [annexed as Exhibit "K"]. The Guidelines are rendered mandatory by W & I Code § 509.5 and any violation of these standards must result in the juvenile hall being closed down under W & I Code § 509 unless said violations are remedied within 60 days of notice of same. The standards which are presently being violated include, but are not limited to IV C (medical services), IV E (academic classroom area), IV G (plumbing installations), IV H (interview rooms), IV I (hallways), IV J (activity areas), IV L (sleeping rooms), IV N (doors), IV O (storage), IV P (maximum capacity—occasionally in violation), VI B (staff-child ratios), VI C (staff training, VI E (staff qualifications), VIII A (admittance procedures), VIII B (counselling and casework services), VIII C (medical and dental services), VIII D (non-punitive detention program), VIII E (academic program), VIII F (recreation program), VIII G (religious program), VIII H (work program), VIII I (food and nutrition), VIII J (laundry services). In addition, the Juvenile Hall is presently being operated and maintained in violation of the minors' rights to freedom of association (visiting) and freedom of expression (letter writing) guaranteed by the First and Fourteenth Amendments to the

United States Constitution. The Hall is not being conducted in all respects as nearly like a home as possible (W & I Code § 851). The Juvenile Hall school is not being conducted in the same manner and under the same conditions, as nearly as possible, as are other elementary and secondary schools of the same school district (W & I Code § 858). Custody, care, and discipline as nearly as possible equivalent to that which should have been given to the minors by their parents are not being provided by the Juvenile Hall staff. Petitioners and the members of their class are not being deprived of their liberty by the least restrictive means necessary to detain them and to effectuate the purposes of the Juvenile Court Law. Said deprivations of liberty in excess of what is absolutely necessary for rehabilitation and security constitutes "punishment" and is in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

4. This application is made upon: the present motion, the declarations of petitioners [annexed hereto as Exhibits "A" through "G"], the declarations of Robert L. Walker and Nina Elsohn Cohn [annexed as Exhibit "H" and "I"], the 1971 Report of the Juvenile Justice Commission of Yolo County [annexed as Exhibit "J"], the Department of Youth Authority's Guidelines for Inspecting Juvenile Halls (July, 1969) [annexed as Exhibit "K"], and Petitioners' Point and Authorities.

Wherefore, petitioners respectfully pray that:

This Court enter an order pursuant to W & I Code § 509 finding the Yolo County Juvenile Hall an unsuitable place for confinement of minors under the age of 18 years and give notice of this finding to all persons having authority to confine such minors pursuant to W & I Code, chapter 2, that said Juvenile Hall shall be closed and not used for the confinement of minors 60 days after said finding has been made unless all practices and conditions in violation of the standards contained in the Youth Authority's Guidelines for Inspecting Juvenile Halls, as enumerated in Point III of Petitioners' Point and Authorities, and all pertinent statutory and constitutional provisions, have been remedied and unless all of the following requirements have been satisfied:

1. Lock-up or isolation shall be used only when the minor is out of control and it is the sole feasible means to protect the physical person of the minor or others. The minor must be released as soon as he or she regains control and no longer presents an imminent physical threat to his own person or the person of others. While in lock-up, counselling shall be offered to the minor within one hour of the isolation, and the offer must be repeated at least every two hours thereafter. A minor shall not be locked up for non-cooperation or use of curse words. Under no circumstances shall a child be kept in isolation more than 8 consecutive hours, and a report describing the out-of-control behavior and all counselling attempts and responses thereto shall be filed with the minor's probation officer.

2. A clear and precise list of rules, regulations and standards of behavior shall be promulgated in language easily understood by minors. Violations of juvenile hall policy shall be dealt with by staff only in accordance with these rules, regulations, and standards of behavior. This list shall be prominently posted and a copy shall be given to each entering minor. An effort shall be made to determine that each minor understands the rules, regulations and standards.

3. A regularly scheduled outdoor recreational program shall be established for detained female juveniles. The program shall include at least 1 hour of outdoor recreation per weekday, and 3 hours per day on the weekend, weather permitting. Insufficient personnel, or facilities, or desire to avoid coeducational contact shall not suffice to deprive the female minors of this outdoor recreation.

4. A regularly scheduled outdoor recreational program shall be established for male and female juveniles who are considered "security risks" whether this classification is based on previous reputation, prior commitments, attitude, behavior or because such juveniles have not yet had a detention hearing. Such a program shall consist of at least one hour per weekday of outdoor recreation and at least 3 hours per day on weekends. Insufficient personnel or facilities shall not be an excuse for denying outside recreation to juveniles.

5. There shall be established an enclosed area suitable for indoor physical recreation for use by both boys and girls during inclement weather. Provision shall be made for physical activity everyday for every juvenile detained regardless of status or weather.

6. A regular maintenance staff shall be hired by the Juvenile Hall so that minors will not be required to do chores as a substitute for such a regular staff.

Specifically, minors shall not be required to do regular maintenance for the County of Yolo, including but not limited to cleaning cars, painting and repairing of the Hall, or otherwise providing a substitute for a regular, paid labor source.

7. The academic program of the Dan Jacobs School shall, as nearly as possible, meet the standards set for other public schools in Yolo County, including but not limited to, length of time spent in academic studies each day, quality and quantity of texts and other books and academic supplies, and quality of instruction. The academic program in the Dan Jacobs School shall be expanded and extended to male and female juveniles detained in Juvenile Hall and classified as "Code 35", "security" or "high-risk", and to minors who have not yet had a detention hearing in juvenile court, in compliance with §§ 12101, 12102, 12551 of the Education Code.

8. A room shall be provided to serve as a girls' classroom that meets the minimum size of 160 square feet for the teacher's desk and work area and at least 28 square feet per child. The building used as a classroom for the boys shall be brought up to standards for fire, safety, security, and space per child. Both school rooms should provide adequate storage for books and other school supplies and be arranged so that individual instruction and evaluation will not interfere with the activities of other children in the room.

9. The sleeping rooms shall contain a minimum of 500 cubic feet and be designed for single occupancy. The doors to the sleeping rooms shall be equipped with a view panel that permits visual supervision of the entire room. The pillows and blankets shall be cleaned and sterilized every ninety days and replaced when torn, unduly soiled or beyond repair. Mattresses, if not provided with a plastic cover, shall also be cleaned and sterilized every ninety days, and replaced when torn, unduly soiled, or beyond repair.

10. Provisions will be made for interviewing and visiting facilities used by parents, siblings, relatives, friends, attorneys, and probation officers that will ensure:

a. Privacy of the juvenile and his or her visitor;

b. Confidentiality of communications between the juvenile and visitor;

c. The room or rooms used for visiting be separate and distinct from the day rooms and/or activity rooms regularly used by juveniles so that those juveniles who have no visitors need not be locked in their rooms;

d. Visiting privileges for parents, relatives siblings and friends be extended to permit visiting by these persons for at least an hour on both Saturdays and Sundays and at least two evenings during the week.

11. The recreational program should be vastly improved and expanded to provide more varied and challenging experiences for detained juveniles. New interests shall be stimulated by introduction to a variety of skills and hobbies. The library should be expanded to include a larger selection of books suitable for juveniles and current magazines. There should be efforts made to utilize community resources.

12. The quality of the food served to the minors must be improved. The meals should be nutritious, attractively prepared, and the menus should be planned specially for children. If necessary, the Hall should provide the services of a cook and upgrade the kitchen facilities so that food may be prepared at the Hall as the service from the county hospital is not intended for the needs of growing boys and girls.

13. The number of letters a child may write should not be restricted. Parents or friends should be permitted to provide additional stamps and stationery beyond the two per week supplied by the Hall. Outgoing mail must not be censored as to content including, especially, criticism of the Hall or its personnel. Outgoing letters to courts or attorneys may not be read by the Juvenile Hall's staff. Incoming mail should be inspected only for content of contraband material.

14. All personnel should be upgraded to meet the educational and experience standards set forth in C.Y.A. Standard VI E.

15. There should be at least 2 male counsellors on duty at all times when the boys are awake. There should be a sufficient number of female counsellors on duty at all times so that all girls will have adequate supervision for indoor and outdoor recreation, and need not be locked in their rooms during non-sleeping hours when they are not out of control or presenting an imminent physical threat to themselves or to others.

16. All minors detained in Juvenile Hall should have a complete medical examination by a doctor within 48 hours of their admission. Provision should be made for a weekly medical clinic to be held at the Hall with a doctor in attendance. Juvenile Hall lay staff members should not attempt to prescribe care or treatment for minors in need of medical attention.

17. Steps must be taken to reduce the punitive atmosphere in both wings of the Hall. A more homelike atmosphere should be encouraged and fostered by improving the decoration and furniture in the halls, day rooms, and sleeping rooms.

18. Under no circumstances and at no time should either wing of the Hall house a population in excess of its rated capacity.

19. An in-service training program of at least 40 hours shall be required before giving counsellors responsibility for supervising minors.

20. All other statutory, constitutional, and C.Y.A. standards shall be complied with including the statutory requirement that the Hall be conducted in all respects as nearly like a home as possible.

Dated: May 22, 1972.

Respectfully submitted,

ROBERT L. WALKER,
MICHAEL WALD,
Attorneys for Petitioners.
ROBERT L. WALKER.

Of Counsel: Nina Elsohn Cohn.

EXHIBIT A—DECLARATION OF DONNA C

I, Donna C, say:

1. I am a 14 year old minor and reside with my parents at [deleted]. I have been at the Yolo County Juvenile Hall since about April 30th. I am charged with being beyond parental control in that I went to a rock concert when my mom said I couldn't go. I have been to juvenile court twice, on about May 3rd and May 8th, and I have a dispositional hearing scheduled for May 22nd.

2. This is the first time I have ever been in this juvenile hall. When I was first admitted, they immediately placed me in a lock-up room. This is a real small room which isn't big enough to hold two beds. It has one bed, a toilet, and a sink, and nothing else. It is dark in there because there's a wire mesh which covers the window and cuts out most of the light. You can't see into the hallway and no one can see into your room because the little window on the door is covered by some cloudy substance. I had nothing to do but sit in this room. After the first day I was allowed to go to school, but I still had to sleep in the lock-up room for about a week. I was told that I had to remain there until I was "trustworthy." I don't understand why I had to stay in this room for a week when I hadn't done anything wrong and the lock-up room is otherwise used for punishment. I didn't like it and don't feel it was fair. You have to ask for something to read.

3. I was formerly in the Juvenile Hall in Yuba City which is much better than the Yolo County Juvenile Hall. There you had activities and things to do. You could play baseball with the boys, volley ball, ping pong, arts and crafts, and they showed films. Here they don't have enough activities for the kids. There aren't enough group activities, and you're not allowed to do anything with the boys. When the boys are doing anything, you aren't allowed to be in the same place. This cuts down a lot in the number of things you can do. A lot of the kids sit around and watch television, read, or do nothing.

4. One thing I don't think has been helpful at all to me is that you are graded on everything you do by the counsellors and the teacher. The best you can get is a 1 and the worst is a 5. If you do real well, you can stay up and watch television a half an hour later than usual. This is just a way of keeping you under control; it doesn't help you improve yourself. You do what you're told so you won't be hassled. You're not learning how to be a better person when you get out.

5. The counsellors are really different in how strict they are and how they grade you. But some use the lock-up as a threat all the time, and lock you up for the smallest reason. I was locked up for 2 hours because I shrugged my shoulders when I was told to change rooms. Mrs. Lucero, who had me locked up, grabbed me and pushed me down the hallway. I was also locked up for 2 hours for talking to the girl behind me in school. Most of the counsellors don't want to help the kids. They are here to get paid for a job, and that job is simply to keep kids locked up.

6. When I came to the Hall, I didn't get a medical exam, and I haven't had one since then. My tonsils were swollen, and one of the counsellors gave me some salt water. I haven't seen a doctor or nurse since coming here. The room I now sleep in is locked at night. There is no toilet, and if you want to go to the bathroom,

you have to bang on the door. Often, you have to bang for a long time for the counsellor to hear you and open the door. Once I had to bang continuously for an hour. In the afternoon and mornings it's very cold in the rooms.

7. One bad thing about my being in a lock-up for the first week was that I wasn't allowed outside, so I didn't get any exercise. Even now we don't go outside for play everyday. It depends on which counsellor you have and what the counsellor wants to do.

8. My mom came to visit on Sunday, May 7th. But it is difficult for her to come on Sunday afternoons or Thursday nights which is the only time visiting is allowed. My brother has his little league games on Thursday night and my mom works on a lot of Sundays from about 7:30 a.m.–4:15 p.m. I also would like to see my sister and brother, but they can't come if it's too crowded in the recreation room (where visiting is held). Since you never know if it will be too crowded, they don't come.

9. The food at the Hall is not good. It's cooked at the hospital and brought over to the Hall where it's heated up. Sometimes the food is almost raw, and sometimes it is cooked too much. The pork chops are so bad you can hardly eat them.

I sure wish there was more to do here and the counsellors tried to help you.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 18, 1972, at Woodland, California.

DONNA C.

EXHIBIT B—DECLARATION OF ARTHUR N.

I, Arthur N.   , say:

1. I am 17 years old. I came to the Yolo County Juvenile Hall on about May 3, 1972. Before coming to Juvenile Hall I lived with my Mother, [deleted].

2. Since coming to Juvenile Hall I have not been permitted to go to school. This is because of two reasons. First, the Juvenile Hall has a policy that no one can go to school until he has been to court. Second, every juvenile in the Hall is given a "code number" which is supposed to reflect his behavior. About 3 days after coming to the Hall I was changed from "Code 10" to "Code 35." I was not told why my code number was changed. As a "Code 35" I am not allowed to go to school. I am also not allowed to go anywhere unless two counsellors are present. This means that I have to stay in my day room a good deal of the time—especially between 8:00 a.m. and 4:00 p.m. because there is often only one counsellor present between those hours. I do not get to go outside everyday. I am allowed outside for ½ to 1 hour about 4 to 5 days a week.

3. In the boys' wing of the Hall there eleven rooms—3 rooms for "trustees" and 8 "lock-up" rooms which have wire mesh over the windows, a toilet, and a sink. On May 16, 1972 there were about 12 boys in the Hall. At least one room had two boys sleeping in it. These rooms are very small and crowded even for one boy, not to mention two. Over the weekends the population of the Hall goes up. Over the weekend of May 13, 1972, for example, there were about 17 boys staying in the Hall overnight. It was very crowded, and at least 2 or 3 rooms had 2 boys sleeping in them.

4. They have many rules in Juvenile Hall for which you are punished by being placed in isolation in a "lock-up" room. I was locked up from 5:00 p.m. to 9:00 a.m. for fooling around by playing cards for punches. When I was locked up, no one came into my room to talk to me, or to explain why I was placed there. Other boys in Juvenile Hall are punished harshly for the slightest breaking of the rules. One boy, David Hoover, opened the hallway door slightly to say "hi" to the girls and was placed in lock-up for 24 hours. If you use any words the counsellors consider "dirty", you are placed in lock-up 1 hour for each dirty word used.

5. The food in the Hall is bad, especially the breakfasts. If I had my choice, I wouldn't eat it. The eggs are cold; in fact, everything for breakfast is cold except the hot chocolate.

6. I have not had any medical exam or seen a doctor since I came to Juvenile Hall. I do not have a mattress cover on my mattress. Nor do I have a pillow case. Instead, they gave me a sheet to wrap around the pillow. Many of the mattresses the kids sleep on are torn, soiled, cut up, and dirty. I have never seen any mattresses cleaned, and they don't look like they have ever been cleaned.

7. I find Juvenile Hall boring because there is so little to do. Most of the time I sit around my room, read, play cards or ping pong, or watch T.V. I wish they offered me more activities to improve myself and take up my time.

I declare under penalty of perjury that the foregoing is true and correct.

Executed at Woodland, California on May 18, 1972.

EXHIBIT C—DECLARATION OF LORENZA VASQUEZ

I, Lorenza Vasquez, say:

1. I am fifteen years old. I just finished spending eight months at the Sacramento County Girls School where I was sent by the Yolo County Juvenile Court for being a runaway. I have finished my time at the Sacramento County Girls School, and on May 10, 19772 I came to the Yolo County Juvenile Hall. No one has told me why I am here. I do not know if a court date has been set for me, or even if I am going to court. I assume that I'm waiting to be placed in a foster home, but no one has discussed this with me at the Hall.

2. Upon coming to the Hall on May 10th I was immediately put in a lock-up room. This is a tiny cell-like room in which you're isolated from everyone else in the Hall. There's something over the window which makes it hard to see outside, and there's some kind of plastic over the small window in the door so you can't see into the hallway. It is real dark at night, and it gets very cold. When I am locked in this isolation room, I feel alone and scared. I am going to school but am not permitted outside until I go to court, and as far as I know, no court date has been set.

3. I have been in the Yolo County Juvenile Hall twice previously, once when I was 12 years old, and once when I was 14 years old. Each time I was at the Hall for being a runaway. On three different occasions when I was 12, I was punished by being locked up in one of the above described lock-up rooms. Twice I was locked up for 24 hours for smoking, but one of those times one of the counsellors, Mrs. Harrington, said I shouldn't be locked up for that and I was released from the lock-up cell. The other time though, I had to remain in isolation for the full 24 hours. I ate in my room, used the toilet that was in the room, and remained inside the room for the full 24 hours. The other time I was placed in lock-up for 24 hours for "cussing" at one of the counsellors. When I was locked-up, on all three occasions, no one came to talk to me about why I was there or my attitude. I just slept the entire time I was locked up.

4. The schooling in Yolo County Juvenile Hall is not good, and you don't learn much. Some of the books are real old and they don't give you any tests. At Sacramento County Day School we had modern books and exams. I brought my math testbook with me from the Sacramento County Day School because the math book they use here is so easy that I wouldn't learn anything I didn't already know.

5. The food is very greasy. It is cooked at the hospital and warmed here and doesn't taste good. When I came to the Yolo County Juvenile Hall last time, I weighed about 95 pounds. When I left, between two to three weeks later, I weighed about 120 pounds. Because the food tastes so bad, I ate a lot of bread. Since the last time I was here, the food hasn't gotten any better. When I was here last time I had very little outdoor recreation. Sometimes I wouldn't go outside more than couple of days a week or even for a whole week at a time.

6. At the school in Sacramento the school was much better than in Yolo, and they had activities for the kids. People came to talk about the drug problem, and they took the kids on trips. Here they don't do those sorts of things, and there is very little for the kids to do.

7. The counsellors give you clothes and a towel and a washcloth upon admission. You receive new clothes once a week, and a new towel and washcloth once every week.

8. The visiting is from 2:00 p.m.–4:00 p.m. on Sundays and 7:00–8:00 p.m. on Thursdays. If you don't have any visitors, you are locked up in your room while the other kids talk to their visitors in the recreation room. I'm not sure why I'm locked up when other kids have visitors, but I guess it's because there isn't any room for me to be any other place.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 18, 1972 at Woodland, California.

LORENZA V.

EXHIBIT D—DECLARATION OF TERRY H

I, Terry H., say:

1. I am a sixteen year old minor. My parents live at [deleted]. I have been in Yolo County Juvenile Hall since May 11, 1972. I was charged with forgery, petty theft, and assault, and I am now here in Yolo County Juvenile Hall. I am just waiting to go to court on May 30 when I hope to be able to go home and live with my parents.

2. I didn't start school at the Juvenile Hall until I went to court Monday, May 15. They usually don't let you attend the school here until you have been to court for your first time. Before I started school I filled out a form and wrote down what I wanted to study. You decide what you will study here. I am taking English, Math, Drama, and Biology.

3. We get to go outside about one hour a day, and about three hours on weekends. I would like to go out more often. When I'm not in school I just sit around and read, and school is only until 11:30 every day. In the afternoon I wish we had more things to do.

4. I would like to have some group discussion here. I think we are supposed to have them, but there haven't been any while I've been at the Hall. I think we should all get together to talk about how people are treated, and what kids are thinking. While I was at Perkins and at Lakeside Lodge, a foster institution at Elsinor, California, I learned to control my anger and fighting. While there we spent most of our time talking to the counsellors and psychiatrists. I listened to them and put it all in my head. I haven't been in any trouble since I've been here at the Hall. At the Lodge, if I didn't want to do something, they explained why it would be good to do it, and you don't punished for not wanting to do it. While at Perkins and Lakeside, I saw a lot of kids who were like I used to be—fighting and angry—and the counsellors pointed them out to me and helped me decide that I didn't want to be like that any more. I think it would be really good if the counselors at the Hall gave that kind of help. But here they mainly give orders and you don't go to them for advice.

5. We have clean up duties here after every meal. We sweep, mop, and buff the halls and day room after every meal. There is a janitor but he only cleans the offices. There is a big cleanup on Saturday mornings. We sweep, mop and buff the floors, and we clean the walls in the rooms, halls, and the dayroom with ammonia. We remove the covers on the lights and clean them. The girls clean the kitchen and mop the floor with ammonia.

6. We get up every day at about 6 to eat breakfast. Then we clean up, and go back to our rooms and are locked in until 8:30 when school starts. We have dinner about 5 or 5:30, and then clean up again. We take showers every night. Then we can watch T.V. until 9 which is bedtime unless you have been good all day, then you can stay up until 11. We could play ping pong, but they don't usually let you set it up at night because it is too noisy.

7. We are allowed to write letters but they read everything that goes out and comes in. You can't have any swear words or any talk about escaping or they won't let you send the letter.

8. My dad works every day and he had to take time off to come and see me because visiting is only on Thursdays and Sundays. I have two brothers that I would like to see but you have to get special permission from Mr. Alcaskus, the third in command so they can come in. The other counsellors won't let them in, they say only your parents can come.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 18, 1972 at Woodland, California.

Terry H.

Exhibit E—Declaration of Maggie G

I, Maggie G say:

1. I am 15 years old. I am a ward of the Juvenile Court of Yolo County having been found to be a runaway (W & I Code § 601). I presently live with my foster parents. I have been living with them for about two and one-half weeks although I continue to go to school and spend my days at the Yolo County Juvenile Hall. Previously, I spent about seven weeks in the Yolo County Juvenile Hall while my court proceedings were going on and afterwards while I was waiting for placement in a foster home.

2. When I was admitted to Yolo County Juvenile Hall in March of 1972, I kept vomiting. I did not see a doctor when admitted, nor did I see one soon thereafter even though I kept vomiting on a regular basis. Finally, 2 weeks after my admission to Juvenile Hall I was taken to a Dr. Schaffer who diagnosed my problem as nerves. I continued to vomit thereafter and I saw a doctor again, and had some x-rays.

3. When I first came to the Hall I weighed 95 pounds. But my weight soon went up to 110 pounds and then I got sick and lost 5 pounds. One reason I gained weight is that I have so little exercise. When I first came, I wasn't

allowed outside because of a policy that you can't go outside until you've had a detention hearing. I subsequently ran away only to later turn myself back in. Afterwards, the counsellors wouldn't allow me to go outside at all except for the last two days I was an inmate at the Hall.

4. At school you are permitted to study the subjects you want to study and not to study others. For the first several weeks I was here I studied history. Now I'm studying English. In the afternoon we have crafts. I have not studied any science, any mathematics, or any home economics. There are no tests. The teacher doesn't really do any teaching unless you ask her a question. This is because all of the inmates are different ages and at different grade levels. They presently range from about 14 years old to about 17 years old although they have had children as young as 9 since I have been here. If you don't do your schoolwork, you may be punished by being placed in lock-up. This is a tiny cell where you must remain. You can't see into the hallway because the window on the door is covered by plastic, and you can't see outside too well because there's a mesh over the window. I was placed in lock-up for 24 hours because I didn't finish my schoolwork and wanted to watch television.

5. There isn't much to do at the Hall, and Saturdays and Sundays are especially boring. On Saturday mornings the kids do the cleaning and maintaining of the Hall. We sweep, mop, wax and buff all of the floors, clean the bathroom and the kitchen. The counsellors supervise. In the afternoon most of the kids sit around and watch television. Sometimes we are allowed to go outside on weekends, and sometimes we are not permitted to do that. Sunday is also boring. There's very little to do except watch television or play records—except for visiting.

6. Visiting hours are from 2:00–4:00 p.m. on Sunday and from 7:00–8:00 p.m. on Thusrday, but you are only allowed to visit for a maximum of one hour. When I didn't have any visitors, I was locked up in my room. Visiting is conducted in the recreation room. It gets real crowded, and there is no privacy. A counsellor stays inside the day room all the time while visiting is taking place.

7. You are allowed to write not more than two letters a week. You must hand the letters to the counsellor who reads them and then takes them to the front office where they are mailed. Sometimes the counsellor will read the letter right in front of you. You are not allowed to write anything bad about a counsellor, and the letters are censored by the counsellors who cross out things you are not allowed to say. The counsellors also read all of the incoming mail.

8. When I first came to the Yolo County Juvenile Hall as a runaway in November of 1971, I was given all of the dirtiest jobs like cleaning the toilets, scraping, and washing. This is a policy which the counsellors follow to scare you. One girl who came to the Hall about five weeks ago, named Vincant Vance, was in one of these lock-up rooms and tried to kill herself. She was released that day.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 18, 1972 at Woodland, California.

MAGGIE G.

EXHIBIT F—DECLARATION OF JOHN F.

I, John F. say:

1. I am 16 years old. My mother resides at [deleted]. I arrived at the Yolo County Juvenile Hall on approximately February 23, 1972. I was charged with truancy and being beyond my parents' control and, I think, also with violation of probation. After remaining at Juvenile Hall for a number of weeks and after having been found a ward of the Juvenile Court, I was transferred to Perkins (C.Y.A. Northern Reception Center) for observation. I remained in Perkins for about 40 days until I was returned to Yolo County Juvenile Hall on approximately May 8, 1972. My dispositional hearing is scheduled for May 22nd.

2. When the Youth Authority returned me to Juvenile Hall on about May 8th, I was classified a "Code 35." This means I can't go anywhere without two counsellors being present. I asked Mr. Bryan why I had been classified "Code 35," and he told me it was because my past reputation wasn't good. He also told me that if I kept "getting smart," he would send me to county jail. For the first seven days I spent in Juvenile Hall after returning from Perkins, I wasn't allowed outside so I got no exercise. May 16th was the first day I was allowed outside where I could get some fresh air.

3. I have been going to school in Juvenile Hall. The teacher asked me what I wanted to study and I told him math. So I study nothing but math in school which runs from about 10:00 a.m. to 12:00 noon. In the afternoon we do crafts from about 2:30 p.m. to 4:30 p.m. We mostly build boxes and work with plastics.

4. I have been coming to Yolo County Juvenile Hall since 1967 and have been

here about 10 times. At least 4 or 5 times I have written letters which were never received. One or two of those letters were to my girlfriend, and the rest were to my mother. All of the letters were similar in that I was critical of my probation officer or the staff of the Juvenile Hall. In one letter I said that my probation officer didn't have any right to put me in the Hall when the recommendation was that I should go home. In another letter I wrote that Mr. Bryan wasn't treating me fairly. I gave these letters to the counsellor on duty, but they were never mailed. I know because I later asked my mom and my girlfriend if they received those letters, and they said they had not received them.

5. I sleep in a small room which has a solid steel bed (no springs), a mattress which is ripped in two or three places, and a sink and toilet. The food is really bad. It is raw, rotten, and oily. It gives you pimples so that when you finally get out of this place your face looks like a mountain. Last time I was confined at Juvenile Hall, I kept getting stomach aches. I quit eating the food, and the stomach aches went away. I never saw a doctor and, in fact, have never seen a doctor since coming here. One kid, John O., developed pneumonia since coming to Juvenile Hall. They sent him home on May 16, 1972.

6. One thing I don't understand is why the kids have to do all the maintaining of the Hall. Every Saturday and Sunday the boys cut the lawn, pull weeds, and wash the county cars (there are about 6 in all). The kids even paint the building. Some of the boy inmates are painting the outside of the building, and some of them painted the bathroom.

7. The visiting hours are restricted to 2:00–4:00 p.m. on Sunday and 7:00–8:00 p.m. on Thursday evenings. This is hard on my mom who works on Sundays and, as a result, can't visit me on that day. When I was at Perkins, they had visiting everyday, and my mom used to visit Thursday nights and Saturdays. Now she can only visit on Thursday evenings. I have two brothers and sisters who would like to visit me and whom I would like to see. Sometimes the counsellors allow them to visit and sometimes they won't. Recently, the counsellors have said that only one's parents can visit.

8. When I first came to the Yolo County Juvenile Hall as a runaway in outside more of the time. The counsellors argue among themselves whether to let me outside. Sometimes they give me permission and revoke it. When I asked Mr. Gimmel if I could go out with the other kids, he told me, he's not going to stick his neck out to let me outside. So I wasn't allowed to go out.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 18, 1972 at Woodland, California.

JOHN.

EXHIBIT G—DECLARATION OF PAUL T.

I, Paul T———, say:

1. I am a 17 year old minor. My mother [deleted]. I came to Yolo County Juvenile Hall this time on May 8, 1972, from Perkins, a Youth Authority Institution. I was charged with battery, under Section 602 (of the W & I Code). My next court date is May 22, when I hope to be able to go live with my uncle in [deleted].

2. The food here is terrible. On Fridays we get fish that stinks and has no taste. Usually on Fridays I just drink milk for dinner. When they have good food or if there isn't enough for everyone to have seconds, you get more only if you have good grades.

3. I have been punished my lock-up, which means being locked in a small room that has just a bed, toilet, and a sink. The window has heavy metal screening on the inside so you can't look out. The last time I was here, I was given lock up for 72 hours for grabbing the shirt of another kid and accidentally hitting him. While I was in lock up I had all my meals in the room alone. They only wake you once softly, and if you sleep through it they take the food away. When you wake up and are hungry, they say just too bad. You don't get the 8 P.M. snack when in lockup. No one comes into the room—its like in prison, some kind of a jail. When I was in for 72 hours I asked for some homework to do but I didn't get it until I was let out. I also got lock up for 12 hours for snapping my towel at another kid in the bathroom. One time the toilet in the bathroom got plugged up and ran over, and I got lock up for that. There is also "shift lockup" where we get locked up while the counsellors change shift. Also there is "G.P. Lockup" or lockup for general purposes. I don't really understand why they do that. I have spent a good part of the last two days painting a log in the parking lot.

4. During visiting hours, the female counsellor watches you and listens to everything you say. One time I was talking to my mom and I used some cusswords and the female counsellor came over and warned me not to use that language.

5. Usually we get to go outside for a half hour or one hour a day. We are usually required to play whatever game everyone else is playing, but sometimes we are allowed to just sit outside. If you are coded 35R—a security risk—then you can't go outside unless there are 2 counsellors out with you. I'd like to be able to go outside more just to do what I want.

6. When you are Code 35 you must eat breakfast in your room. At noon if a 2d counsellor comes on duty, you are let out. You don't go to school. If there isn't a 2d counsellor, you eat lunch in your room, too. You can just go crazy sitting in the rooms. The last time I was here, I got code 35 because I was outside and talking to my Probation Officer, and the counsellors, Fred Chabiel and Joel Ondo, told me to go inside. I was angry and threw the basketball down, and I was changed to Code 35 for several days. I think the counsellors are harder on the kids who have been to Y.A.

7. I am now sharing a room with another boy. Our room has only a bunk bed in it. There is no toilet or other furniture, the room is so small there isn't room for anything else. My mattress is dirty and cut and torn up. There is no cover on the mattress. I have 2 sheets that I have had the whole time I've been here. The room is sometimes as cold as an icebox. If you have to go to the bathroom during the night you have to bang on the door.

8. I haven't been helped during any of the time I've been in the Hall. It makes you mean, and you just want to get revenge. You see just the four walls, and when you are locked up you yell at anyone who comes by the window like a wild man.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 18, 1972, at Woodland, California.

PAUL T.

EXHIBIT H—DECLARATION OF ROBERT L. WALKER

I, Robert L. Walker, say:

1. I am an attorney duly admitted to practice in the courts of California. I am employed by the Youth Law Center, 795 Turk Street, San Francisco, which is an Office of Economic Opportunity funded project of the Legal Aid Society of San Francisco dedicated to law reform in the Juvenile and school area.

2. On May 11, 1972 Nina Cohn, a law student at the University of California at Davis and a legal intern with the Yolo County Office of the Legal Aid Society of Sacramento County, and I talked to a number of minors at the Yolo County Juvenile Hall about conditions at the Hall.

3. During the time we spent at the Hall I measured the size of one of the rooms in which the girl inmates sleep. The room measured 8 feet long by 4⅔ feet wide. I did not measure the height of the room, but I approximate that the room was about 10 feet high. The room would, thus, contain approximately 373 cubic feet, or far less than the minimum of 500 cubic feet required by Standard IV(L) of the Department of Youth Authority's Guidelines for Inspecting Juvenile Halls (July, 1969).

3. The other rooms appeared to be the same size as the room I measured. The room I measured, and several other rooms, contained a double decker bunk bed (either made or unmade) and nothing else. There was no toilet or sink in these rooms.

4. Three other rooms were also approximately the same size and contained a single bed, a sink, and a toilet. These rooms were dark although I observed them early in the afternoon. The windows to the outside was covered by a heavy wire mesh which prevented much of the daylight from penetrating the rooms. The doors to these rooms had a small square pane of glass which was covered by a piece of plastic. The plastic was opaque, and when the door was closed to one of these rooms, it was impossible to see into the room from the hallway or into the hallway from the room. Several of the female inmates of the Hall told me that these rooms were used as lock-up facilities where all girls stayed upon first being admitted to the Hall for a week or two weeks and where girls who were being punished were placed in isolation for from 2 to 24 hours.

5. On May 11, 1972 I also measured the girls' classroom. The room contains 10 desks for students plus one teacher's desk. It is small and cramped. The total floor areas of the classroom measured approximately 18 feet by 8⅓ feet or 150 square feet. This includes the teacher's area which measured approximately 5⅓ feet by 2¾ feet or about 14⅔ square feet. I was told by one of the girls attending school at the Yolo County Juvenile Hall, Maggie G, that there were seven girls presently attending school there. Hence, the classroom fails to meet the requirement of Guideline IV E that there be a minimum of 160 square feet for the teacher's desk and work area and 28 square feet per student.

6. I also measured the hallway in the girls' wing of the Juvenile Hall. This provides access between the sleeping rooms and the recreation room. The hallway is approximately 4⅓ feet wide, although Standard IV I of the Guidelines for Inspecting Juvenile Halls require such hallways to be no less than six feet wide.

7. There was no separate dining room or interview room. Upon information and belief, the recreation or day room is used for these purposes. The door to the day room is solid, and there is no panel which would permit visual supervision of interviews while allowing privacy between the minor and his visitor.

8. Nina Cohn went into the ladies room and told me that there were 3 sinks, 3 toilets, 1 shower, and 1 bath. No doors separated the toilets or shower from the rest of the bathroom. There were, according to Nina Cohn, no toilet seats on the toilets.

9. When Nina Cohn and I first entered the recreation room a girl was sitting in the room. Mrs. Lucero, a counsellor, asked her to leave. The girl left her seat and began to slowly leave the room. As she reached the point where Mrs. Lucero standing, Mrs. Lucero grabbed her by her wrist and pulled her arm back so that it was almost behind her body. While holding the girl in this position, Mrs. Lucero told the girl that her "attitude" was bad and that if she didn't change it, she would be spending a lot more time looking at the world "from inside." Mrs. Lucero released the girl and she slowly left the recreation room.

10. While at the Juvenile Hall I read certain notices and regulations which were posted near the recreation room. One said "The evening program is planned by your Supervisor and usually consists of watching T.V. [crossed out] activities." Another provided that visiting hours for parents or legal guardians were from 2:00 p.m. to 4:00 p.m. on Sunday and from 7:00 p.m. to 8:00 p.m. on Thursday. The regulations provided that other members of the inmates' immediate family must obtain special permission to visit. Nothing was said about visits by persons other than members of the inmates' immediate families. Still another regulation provided, "You may write letters to immediate members of your family" without specifying whether letter writing to anyone else was permissible. Finally, a posted notice stated, "All Juveniles are placed in initial 24 hour isolation."

I declare under penalty of perjury that the foregoing is true and correct. Executed on May 19, 1972 at San Francisco, California.

ROBERT L. WALKER.

EXHIBIT I—DECLARATION OF NINA ELSOHN COHN

I, Nina Elsohn Cohn:

1. I am a law student at the University of California at Davis and a legal intern at the Yolo County office of the Legal Aid Society of Sacramento, California.

2. On April 6, 1972, I talked to several counsellors at the Yolo County Juvenile Hall about conditions and activities at the Hall.

3. I spoke with Linda Harrington, a female group II supervisor. She told me that she is the only female counsellor with a B.A. degree, and said that she has great freedom in running the girls' side of the Hall. The main thrust of the program is to get a child to accept responsibility for his or her own action, and she felt this is necessary before any improvement is possible. Ms. Harrington told me that the girls attend school only after their detention hearing which can be as many as five days after intake. The morning is devoted to academics, the afternoon to crafts. She described the grading system that determines privileges and punishment. 1 is the best grade, and can be earned if a child functions normally, follows the rules and volunteers to help on chores such as emptying the dishwasher or folding laundry. 5 is the worst grade, and is given if a child refuses to do something and gets the group to go along with her, or for physical abuse. Lock up is the usual punishment for a grade of 5, but some counsellors

also give lock up for a grade of 4. Girls are graded on 3 shifts plus school every day. Lock up for less than 8 hours is unofficial, and used to separate a child from the group. If more than 3 hours lock up are given, a special incident report must be written with an explanation and justification.

4. Ms. Harrington told me that she thinks the food is terrible. It is prepared at the county hospital and reheated in the old stove in the kitchen. The food is greasy and starchy. She often can't recognize what the food is. She felt this is particularly bad as the kids mark time by the passage of meals. The girls clean up after all the meals including doing the dishes for the boys. The girls also make an evening snack for the whole group.

5. She explained that visiting hours are restricted because there isn't enough space or staff to supervise the visitors. The counsellor on duty during visiting hours turns in a report of interaction between the parent and child to the child's probation officer. Another reason for limited hours is that parents act childish and try to give their children cigarettes.

6. I also spoke with Fred Chabiel, on April 6, 1972. He told me that he has a B.A. in criminology, and training in reality therapy and family counselling. He told me that the purpose of Juvenile Hall is only to provide detention for minors who fit W & I Code § 601 and § 602, but that he tries to help the detained children.

7. Mr. Chabiel told me that any child over 16 who has the permission of his parents is allowed 4 cigarettes a day. This is a privilege, not a right, and the cigarettes can be taken away for various reasons. He said that lock up is used as a punishment for fights, escape attempts, defiance or disrespect. He gives 1 hour lock up for every curse word a child uses around him, and explained that this is for the child's own good. So he can learn to speak properly for job interviews. He feels that the physical size of the counsellor is important, as he can pick up a kid and put him in the shower if necessary.

8. Mr. Chabiel said the school program at the Hall is used for kids who are dysfunctional at their "outside" school. This requires active attendance, if they miss 1 day they get 24 hours lock up in the Hall. There is also a Behavior Modification program in which a child meets with a probation officer, school authorities, and his or her parents once a week. If they decide that the child is behaving poorly, he or she can be put in Juvenile Hall for a weekend, from Friday 6 p.m. to Sunday 6 p.m.

9. Visiting hours are on Thursday, 7–8 and Sunday 2–4. Visitors must be supervised as they aren't allowed to bring in food, candy, or cigarettes. There are insufficient facilities for more extended visiting, according to Mr. Chabiel.

10. I also saw the building used as the boys' schoolroom on April 6, 1972. It is very old and dilapidated, although quite roomy. The floor was bare wood, and creaked and moved as we walked across it. The building was set up as a classroom with about 12 desks for inmates. The other half is devoted to woodworking equipment and a few power tools, and a kiln. I did not have an opportunity to measure the room.

11. On April 10, 1972, I again visited the Hall and spoke with Ron Gimmel, a group I supervisor. He described the divisions of the day into morning devoted to academic and afternoon devoted to crafts and recreation. Card playing, ping pong and watching T.V. are the main activities in the afternoon according to him. Children who are considered security risks may continue their education inside if they ask to do so, but they don't go out to the schoolroom. Mr. Gimmel told me that his qualifications for the job consisted of a B.A. in psychology and some courses he has taken towards his Master's degree.

12. Mr. Gimmel said that isolation or lock up is used both as a punishment for physical aggression or non-cooperation and also as a stimulus for behavior modification. For a "slow" child he sets out a specific behavior pattern and the child is locked up if he doesn't meet that pattern. Children are allowed to bring books, games and puzzles into lock up.

13. Mr. Gimmel estimated that the inmates spend 90% of their time in watching television. As an explanation for this, he said there isn't enough staff to occupy all the kids at the same time. He feels that the kids aren't interested in doing things, and thinks they should have to be creative also. As far as he knows, there is no effort to bring in community resources.

14. Formal visiting is restricted to 3 hours a week. According to Mr. Gimmel, there is no reason to allow parents more visiting, as they have already messed up their children.

15. Mr. Gimmel saw his main purpose as confining the kids, that this overrides everything else. He feels he is paid a salary to confine the child.

16. On May 11, 1972, I again visited Juvenile Hall with Robert L. Walker, an attorney employed by the Youth Law Center in San Francisco. We talked with several more inmates. I also measured the room in which we interviewed the inmates that is also used as a sleeing room. It measured approximatley 4⅔ feet by 8 feet long. I did not measure the height of the room, but it was about 10 feet high. The room contained about 373 cubic feet, or considerably less than the minimum of 500 cubic feet required by Standard IV(L) of the Department of Youth Authority's Guidelines for Inspecting Juvenile Halls. (July, 1969).

17. There were approximately 11 sleeping rooms. Some of these had double deck beds, and nothing else. There was no sink, toilet or drinking fountain in these rooms. The room I measured had only a single bed. It consisted of a metal platform, and a very stained mattress. I sat on the bed during several of our interviews and I found it extremely hard. The window to the outside was covered by a heavy wire mesh, so that you could not see outside. The door had an open panel at about eye level that had no covering, glass or otherwise. This permits a person inside the room to reach outside. There was another opening in the door about 10 inches above the floor that also had no covering.

18. On May 16, Robert L. Walker and I spoke with Leroy Ford, the Chief Probation Officer, concerning our investigation of the Juvenile Hall. We told Mr. Ford that I would be using the information as the basis for a paper for a course at law school, and that I was also a legal intern at the Legal Aid Society in Woodland. We also told him that Robert Walker is an attorney with the Youth Law Center in San Francisco. We explained that we had not yet decided what we would do with the results of our investigation. Mr. Ford said he was aware of the substandard condition of the Hall, and said that the schoolroom was "a joke." He told us about the plans for a new hall which he estimated would be ready for occupancy in three years. When pressed, he admitted this was an optimistic estimate. Mr. Ford indicated that his concern about our investigation was prompted by the fact that any official investigations had to be approved by his superiors. He gave us a copy of the reports that the Yolo County Juvenile Justice Commission prepared for Judge McDermott following their 1971 inspection of the facility.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 19, 1972 at Woodland, California.

NINA ELSOHN COHN.

EXHIBIT J

COUNTY OF YOLO,
Woodland, Calif., May 7, 1971.

The following report by the Juvenile Justice Commission of Yolo County supports the urgent need for construction of a new Juvenile Hall for the County. The report points out the serious, even dangerous, deficiencies of the present facility. Under existing conditions, children cannot be properly educated, protected from more aggressive or perhaps homosexual inmates, or helped to straighten their twisted behavior.

This report should be of interest to every citizen of the County for each year some seven hundred of our children are exposed to the Yolo County Juvenile Hall. "It is better to correct a delinquent than to support a criminal" and the job must begin at the Juvenile Hall.

Federal funds are available for 50% of the construction costs of a new detention facility. We are soliciting the support of those who agree that our children deserve better treatment. We suggest a first-hand tour of our Juvenile Hall is the most convincing evidence of our problem. Interested persons or groups may contact me at 666-8256.

LEROY FORD,
Chief Probation Officer.

JUDGE MCDERMOTT: The Juvenile Justice Commission of Yolo County presents its report of the inspection of the Yolo County Juvenile Hall.

YOLO COUNTY JUVENILE HALL

The Yolo County Juvenile Hall was built before the present "Standards for Juvenile Halls" was adopted. So, by virtue of the "grandfather clause," the Hall is accepted for occupancy, but by no other means does it meet the standards.

1. It is not "as nearly like a home as possible."[1] (Section 851 W & I Code) Materials used in the construction and interior walls may be durable but do not "add warmth" to the atmosphere. A different type of floor covering should be used as asphalt tile is too easily damaged and is missing in many areas. There could be some improvement made in decor by use of bright paint, etc., the girls' side did show some attempt at improving the individual rooms, but the boys' side was rather bleak.

2. Rooms are inadequate in size for even single occupancy. 460 cubic foot vs. 500 cubic foot minimum required by the code. Often they must hold two juveniles when the Hall is overcrowded.

3. The doors do have an observation panel but "complete visual supervision of all parts of the room" is not possible. The panel is open on several of the rooms and children can reach out through this. This is not a safe situation.

4. To quote from the C.Y.A. inspection report: "the plumbing installations and fixtures are substandard. There are insufficient numbers of showers, washbasins and water closets for the number of children detained." In addition, the bathrooms and showers are not "easily supervised". A member of the staff must be present to make supervision possible. The plumbing in each individual room should provide a drinking fountain, washbasin and toilet. Yolo County's Juvenile Hall does not. The plumbing is not arranged so it can be repaired from "outside the room."

5. The hallways are less than the required width. The turn at the end of the hallways in both wings does not allow for "maximum visual supervision of hallways," it makes it impossible.

6. There are no interview rooms, one per living unit is the recommended ratio. There is no room suitable for group counseling or for counseling a child in privacy. When parents visit, the minors not being visited must be locked in their rooms while the activity rooms are being used as visiting rooms. This takes a lot of staff time, creates confusion and certainly has a negative effect on the minors being locked up.

7. The activity room would be adequate in size were it not also used for dining. This requires an additional 15 square feet of floor space per child. At present the room must be cleared and tables set up and arranged for each meal. This makes creative activity difficult or impossible.

8. School Building—Should be in accordance with the provisions of Article #14 of the Welfare and Institutions Code. Yolo County houses its classroom in a dilapidated temporary building. It is inadequate by all standards for an educational program, security, fire, safety, and space allowed per child.

9. Storage areas are inadequate—both for the individual child and for supplies. The requirement is nine cubic feet of secure storage space for personal clothing and belongings—there is none at present. Total storage for supplies should be six and one-half square feet of floor space per child for clean clothing and cleaning supplies. For a centralized storage room, twelve square feet of floor space per child is required. Temporary sheds back of the building presently provide for this.

10. There is no screening in the windows of the girls' unit. "There is no security sash used in any of the windows in the Hall."

11. "Sleeping rooms are not equipped with night lights for night supervision. Switches are not provided for central as well as individual control of illumination nor are they tamper proof."

12. The control centers are not located to give staff "maximum supervision" of hallways, activity rooms, etc. In fact there is no planned control center in the Hall.

In addition the Juvenile Hall has been overcrowded for ten of the last nineteen months, based on average daily attendance. (See accompanying graphs) This does not, however, give a true picture of the overcrowding that occurs during peak periods when sometimes as many as six girls must sleep in sleeping bags on the floor of a former utility room now used as a supplementary classroom. Also, there are many times when the rooms, not up to standards for single occupancy, must hold two children. The Probation Department has created a weekend work project program to take care of cases that might otherwise be assigned to Juvenile Hall for weekend detention. This helps with some of the load on the Juvenile Hall.

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[1] Sections in quotes are from Guidelines for Juvenile Halls or the California Youth Authority Inspection Report.

A daytime supervision program has been devised to provide schooling and guidance during the school day for youths who cannot function in the public school system, even in the special continuation program. This places an added burden on the already busy teacher. An extra teacher has been provided, and the program fills a vital need. This creates even more congestion in the unit. In planning a new Juvenile Hall, consideration should be given to providing for this type of program.

INTAKE

Intake procedures have been improved to reduce detention as much as possible.

1. An Intake Officer has been appointed who has no other duties but intake.
2. Part of the Juvenile Hall staff has been upgraded to Group Supervisor II position, equivalent to Probation Officer I. This makes it possible for intake to occur on a twenty-four hour basis, including the weekends.
3. No child can be accepted without a written report from the police regarding the offense for which he was arrested.

Some of the overcrowding is caused by children being held in Juvenile Hall after adjudication due to lack of availability of placements. Yolo County has developed a proposal for the establishment of a Group Home which is in the process of being presented to the California Council on Criminal Justice. If funded, this should relieve some of the stress on Juvenile Hall and will hopefully be the first in a chain of such homes.

STAFF

The Juvenile Hall staff has been upgraded in the past two years with those Group Supervisors who have the qualifications now called Group Supervisor II. These provide for twenty-four hour intake in the Hall by being present nights and weekends when the regular intake officer is not available. This position also provides an incentive for Juvenile Hall staff, since it presents the possibility of promotion.

The staff-child ratio is excellent, providing one staff member per eight children.

Staff educational requirements are being met: Group Supervisor I, two years of college; Group Supervisor II, a B.A. degree or its equivalent; Assistant Superintendent of Juvenile Hall, a B.A. degree plus two years experience; Superintendent of Juvenile Hall, a B.A. degree plus three years experience.

Staff members do not attend the outside conferences, "professional institutes and meetings" stated in the standards. There are regular staff meetings twice a month that include inservice training, these given by people brought in from outside, such as U.C. Davis and Sacramento State, to provide training. Members of the Health Department give programs in their specialties. Training is also given on specific staff programs.

New staff is frequently hired on a part-time basis to start. This period acts as a training and orientation session. The part-time worker is supervised by working with a permanent member of the staff. When hired on a full-time basis, they are already familiar with their duties.

Attitude of the staff toward the children seems excellent.

ACTIVITIES

The School Program provides the main source of activity for the residents of Junvenile Hall. The teacher is present at the school for eight hours. The program has been recently upgraded by the addition of another teacher. The morning session is then divided by the boys studying in the school room, the girls using the former utility room as a classroom, plus the halls and dayroom. At the time of inspection, the special daytime supervision program added five boys and five girls to the population of Juvenile Hall, adding to the already crowded conditions. The school has a dedicated teacher who manages to flexibly meet the educational needs of children who are in and out of Juvenile Hall for sometimes quite short periods and who have all sorts of educational problems and deficiencies. Individual attention is given to each child and improvement is often remarkable.

The afternoon session is devoted to coeducational activities such as crafts and supervised sports. The school programs ceases for six weeks in the summer. This may be changed if the additional teacher can carry on over the regular teacher's vacation.

Recreational activities consist of T.V., games—checkers, chess, ping-pong, basketball and softball. There is room for creative art activity in the schoolroom.

PROGRAM

There has been an attempt to incorporate treatment-oriented practices in handling the children in Juvenile Hall as opposed to the usual authoritarian approach. Reality therapy forms the basis of the philosophy for treatment in the Hall. The thrust is to hold the child responsible for his actions with the staff implementing this by being models of responsibility themselves. The therapy teaches insights into motivations for behavior. The children are encouraged to understand their reactions to situations they are involved in, such as contacts with police, being detained, going to Court, etc. They are encouraged to plan and look toward goals and see themselves in the future.

The therapeutic community suggested by the Venezia Report is a reality with each member of the staff considering himself and herself a contributor toward the rehabilitation of the child. In addition, the staff members often establish such meaningful ties with the children that they are often called on for advice and/or consolidation when the child is out of Juvenile Hall.

Juvenile Hall staff work with the Probation staff to reciprocally exchange information for an ongoing assessment of the child's needs.

OUTSIDE ACTIVITIES

Volunteers are the backbone of the outside activities program. They help in taking youngsters to such things as ball games, museums, zoos, parks, beaches, fishing, and mountain snow trips. Teams from Juvenile Hall also compete in City League competitive sports.

The Volunteers from the Lawyer's Wives also tutor, give lessons in hair styling, dressmaking, knitting and crocheting. A modern dance class has been started recently. Donations such as the curtains for the dayroom, yarn and books are made to Juvenile Hall by service groups.

FOOD

The committee ate lunch at Juvenile Hall with the youngsters and found that the food was ample and good. The youngsters would like more foods such as hamburgers, etc. One child said he gained weight every time he came to Juvenile Hall. The County's nutritional consultant went over the diets provided with the hospital's dietitian and found them adequate. The hospital does change the menu for Juvenile Hall occasionally for some meals to provide some more suitable for youngsters.

MEDICAL PRACITICES

There is no official medical examination of the child at intake. The Juvenile Hall staff is solely responsible for the physical inspection of each child the first day he is in Juvenile Hall. A checklist is used for this. If problems are found the child is taken to a physician. The Assistant County Health Officer visits the Hall regularly. Since the County Hospital is often lacking in availability of services, the Hall Staff takes the child to a private physician when necessary, a saving in staff time and actual cost.

RECOMMENDATIONS

It is our firm recommendation that the present Juvenile Hall be replaced with a new facility and that planning for this start immediately.

It is felt that the inadequacies of the present building, both in size and layout greatly impair the program, are violations of the Standards for Juvenile Halls, and are insurmountable within the framework of the present building.

That every effort be made to strengthen indepartmental meetings for a concerted effort to solutions of the problems facing the children of Yolo County.

This effort has been made in the past but unless continuing effort is made in this direction, it is all too easy for each department to see its activity as the whole, instead of part of the whole.

That training efforts be continued and upgraded by direct response to the stated needs of the staff.

A continuing active evaluation be instituted whereby staff needs are solicited and approaches thereupon developed to meet these needs.

SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF YOLO JUVENILE COURT

In re YOLO COUNTY JUVENILE HALL; No. 5326;

MEMRANDUM DECISION AND ORDER

The petitioners are minor children confined in the Yolo County Juvenile Hall. They seek to close the Yolo County Juvenile Hall under the provisions of Welfare & Institutions Code § 509. This action is, in addition, brought as a class action on behalf of any other minors who are at any time inmates of the Juvenile Hall. Petitioners are represented by Robert L. Walker and Peter Bull from the Youth Law Center of San Francisco.

On May 25, 1972 the Court ordered that petitioners' pleadings, in which no respondents or defendants were named, be served on respondents Austin Bryant, Director of the Yolo County Juvenile Hall, Leroy Ford, Probation Officer of Yolo County and Charles Mack, as County Counsel of Yolo County. Thereafter, respondents demurred and moved to strike petitioners' motion on the grounds that there was a defect of parties and that the motion and affidavits did not state facts to constitute a cause of action. Respondents also sought on order *in limine* for the exclusion of evidence. On October 6, 1972 the respondents' demurrer, motion to strike and motion for exclusion of evidence were denied by an assigned judge.

On October 25, 1972 the motion came on regularly for hearing. Evidence was received, a further hearing was scheduled, briefs were filed, the Court inspected the Juvenile Hall on April 3, 1973 and the matter was submitted for decision by the Court.

PROCEDURAL PROBLEMS

Respondents, in their brief, again atack the propriety of this proceeding, reasserting that the pleadings fail to state a cause of action because no persons are named as plaintiffs and defendants and because Welfare & Institutions Code § 509 requires an administrative act of inspection by the Juvenile Court Judge and does not establish a special proceeding.

Petitioners contend that the rulings of this Court on October 6, 1972, when such contentions initially were urged by respondents, have become the law of the case.

Recognizing that this action involves an uncharted area of law and a multitude of procedural problems which could require countless hours to resolve, and being mindful that 10 days were devoted to taking evidence with respect to petitioners' motion, the Court adopts the point of view that by this proceeding a Judge of the Juvenile Court of Yolo County has inspected the Juvenile Hall of Yolo County and by this order is noting, in accordance with the requirements of Welfare & Institutions Code § 509, the suitability of the Juvenile Hall of Yolo County as a place for confinement of minors. Procedurally speaking, therefore, the Court has inspected the Juvenile Hall under § 509 with the aid of petitioners, respondents and their respective counsel.

THE AUTHORITY OF THE JUVENILE COURT JUDGE UNDER SECTION 509

II

Section 509 provides in part that:

> "If . . . such a judge of the Juvenile Court . . . after inspection of a . . . Juvenile Hall . . . finds that it is not being operated and maintained as a suitable place for confinement of minors, the Juvenile Court . . . shall give notice of its finding to all persons having authority to confine such minors . . . and commencing 60 days thereafter such . . . Juvenile Hall . . . shall not be used for confinement of such minors until such time as the judge . . . finds, after reinspection of the . . . Juvenile Hall . . . that the conditions which rendered the facility unsuitable have been remedied, and such facility is a suitable place for confinement of such minors."

The principal thrust of this section is that the Judge must find whether the Juvenile Hall is being operated and maintained as a suitable place for confinement of minors . . .". In determining whether the Hall is a suitable place for confinement of minors, the Judge must consider the manner in which it is "operated and maintained", a consideration which involves more than merely an evaluation of the physical facilities of the Hall. On the other hand, he is required to limit his finding to whether or not the Hall is a "suitable place for confinement of minors." If he finds that the Hall is such a "suitable place", his power to act further is terminated. However, if he finds that the Hall is unsuitable, he must give notice of his finding, and, commencing 60 days thereafter, the Juvenile Hall shall not be used for the confinement of minors until such time as he finds that the conditions which rendered it unsuitable have been remedied. The Judge's powers thus are narrowly delineated. He has no power to order, as some have suggested that group homes should be used instead of a Juvenile Hall, that Juvenile Halls are bad or that some acceptable methods of operating a Juvenile Hall should be used instead of others. His finding must be limited to the "suitability" or "unsuitability" of the Juvenile Hall in the totality of its circumstances.

III

HISTORICAL BACKGROUND

For years there have been persistent and emphatic complaints that the physical plant of the Junvenile Hall is inadequate.

In 1964 the Yolo County Grand Jury reported:

> Juvenile Hall—Physical Plant.
>
> The hall's design capacity . . . is now being consistently met and at times exceeded. The poor design of the building in terms of security is an increasing problem under capacity loads. In an interview with jury members the Chief Probation Officer advised that the hall was adequate under present conditions but could stand no additional load. In an inspection by the Grand Jury the hall was found to be clean, pleasantly decorated and the design deficiencies dealt with as well as could be expected.

The 1964 Grand Jury recommended that "a plan for a new Juvenile Hall should be started in fiscal 1965 for construction in 1967." Following this recommendation, the Board of Supervisors included a new Juvenile Hall as fourth in rank of fifteen items to be financed by a $7,100,000 bond issue that was rejected by the voters on June 7, 1966. The items with first, second and third priority were: Land acquisition, county jail and Yolo General Hospital.

In his Annual Report for 1970, the Probation Officer of Yolo County reported that:

> Overcrowding at the junvenile hall is becoming a most serious problem. A recent survey revealed that over a twelve-month period the rated capacity of 17 was exceeded nearly half of the time. On an increasing number of occasions youthful inmates must sleep on the floor of the day room. Under these conditions the children cannot be properly educated and protected from more aggressive or perhaps homosexual inmates.
>
> According to state standards, the facility is inadequate in many respects. Both the California Youth Authority and the Yolo County Juvenile Justice Commission have called attention to the dangers inherent in the existing structure. Since we cannot project a new facility for at least five years, we can look forward to intensification of an already difficult situation.

In 1970 the Department of Youth Authority inspected the Yolo County Juvenile Hall under the provisions of § 509, reported that "Yolo County needs a larger and modern Juvenile Hall and should begin plans to construct one . . . We approve the Yolo County Juvenile Hall for its designed capacity of 11 boys and 6 girls."

In 1971, after an inspection of the Juvenile Hall, the Juvenile Justice Commission of Yolo County voiced many criticisms of the Juvenile Hall and recommended:

> "1. It is our firm recommendation that the present Juvenile Hall be replaced with a new facility and that planning for this start immediately.
>
> It is felt that the inadequacies of the present building, both in size and layout, greatly impair the program, are violations of the standards for Juvenile Halls, and are insurmountable within the framework of the present building. * * *"

In its criticism of the school building the Juvenile Justice Commission concluded that "It is inadequate by all standards for an educational program, security, fire, safety, and space allowed per child."

In commenting on the above-mentioned report of the Juvenile Justice Commission, the Yolo County Probation Officer, by letter of May 7, 1971, wrote:

> "The following report by the Juvenile Justice Commission of Yolo County supports the urgent need for construction of a new Juvenile Hall for the

> county. The report points out the serious, even dangerous, deficiencies of the present facility. Under existing conditions, children cannot be properly educated, protected from more aggressive or perhaps homosexual inmates, or help to straighten their twisted behavior.
>
> This report should be of interest to every citizen of the county for each year some 700 of our children are exposed to the Yolo County Juvenile Hall. 'It is better to correct a delinquent than to support a criminal' and the job must begin at the Juvenile Hall."

In 1972 the California Youth Authority again inspected the Yolo County Juvenile Hall and reported:

> "The inspection indicates general compliance with the minimum standards established in accordance with § 509.5 of the Welfare & Institutions Code.
>
> At the time of the inspection the Juvenile Hall was over the maximum established capacity. A review of the records for a six-month period from January to June 1972 indicated that the maximum capacity of 17 children was exceeded on 98 days. This problem has been brought to your attention in the past as a result of previous inspections."

A letter from the Woodland Fire Department to the State Fire Marshal, dated March 2, 1972, reported:

> "There is an old quonset hut building being used for classroom at this time and it is a fire hazard. They have shop tools and regular school classes in this building. There are only approximately 10 to 12 students in this building at one time. The county is planning for new facilities at this time."

During the calendar year 1971 there were 980 admissions to the Yolo County Juvenile Hall. 23% of these admissions, or 313, were for runaway or incorrigibility, 81 were for violations of court orders, 25 were for truancy, 22 were for glue-sniffing and 17 for vagrancy and curfew, and 4 for being dependent or neglected children, 12 for running away from placement and 47 for change of placement. Overall 53% of the admissions to Juvenile Hall in 1971 were for the conduct enumerated above. In addition, there were 99 admissions to Juvenile Hall designated as "courtesy holds", "court commitments", or "awaiting institution and delivery", and 54 admissions for being drunk or violating the liquor laws. Of these 980 admissions to Juvenile Hall during 1971, 280 were girls. Of this group 71 were there for incorrigibility, 6 for truancy, 87 for runaway, 10 for vagrancy or curfew, 23 for violation of a court order and 4 for being "dependent" or "neglected". Overall, 201 of the 280 admissions of girls to the Yolo County Juvenile Hall during 1971, or 72%, were for the conduct described above.

IV

THE AUTHORITY OF THE CALIFORNIA YOUTH AUTHORITY

In 1969 the California Legislature required the Department of the Youth Authority to establish standards for the operation and maintenance of Juvenile Halls. Welfare & Institutions Code § 509.5. This legislation also provided that "Any violation of such standards shall render a Juvenile Hall unsuitable for the confinement of minors for purposes § 509."

Section 509 of the Welfare & Institutions Code requires the Youth Authority, as well as the Judge of the Juvenile Court, to conduct an annual inspection of each Juvenile Hall in the State. If such inspection determines that a Juvenile Hall is not suitable for confinement, proper notice must be given and the Juvenile Hall may not be used for confinement unless a reinspection by the Youth Authority shows that unsuitable conditions have been remedied; and the Juvenile Hall is then a suitable place for confinement of minors. Consequently, the responsibilities of the Youth Authority and those of the Juvenile Court Judge under § 509 are separate but identical. In Yolo County each has a responsibility to inspect the Juvenile Hall and each must determine if it is a suitable place for the confinement of minors.

In July 1969 the CYA prepared a manual of standards or guidelines to be used in determining the suitability of Juvenile Hall under § 509. The standards suggested are said to be minimum guideposts for counties that have not achieved a minimum level of service, yet they are higher standards than are necessary for the protection of public health, safety and welfare. The standards applicable to buildings and grounds specify, for example, the plumbing installations in each sleeping room (i.e. drinking fountain, wash basin and toilet, arranged so that repair may be made from outside the room), 500 cubic feet of air space per person in each sleeping room, that each hallway shall be no less than six feet wide, that a minimum of 30 square feet of clear space per minor shall be provided in the activity room, that at least 15 square feet per person shall be the minimum allowance in the dining area, that there shall be a minimum of nine cubic feet of secure storage space for each minor, etc.

The buildings and grounds of the Yolo County Juvenile Hall do not comply with many of the standards applicable to buildings and grounds. With respect to all of the standards applicable to buildings and grounds, however, the CYA incorporated the following "grandfather" clause:

> "An existing Juvenile Hall, built in accordance with construction standards in effect at the time of construction, shall be considered as being in compliance with minimum standards, unless the condition of the structure is determined to be dangerous to life, health or welfare."

Petitioners assert that the grandfather clause is invalid for a host of reasons. Without enumerating them, the Court finds none of them persuasive. The interpretation of § 509.5 petitioners ask the Court to adopt would conflict with a number of maxims of statutory construction: A statute does not operate retrospectively unless the legislature expressly has so declared. *DiGenova* v. *State Board of Education* 57 Cal.2d 167, 173 (1962). A statute must be given a reasonable and common sense construction—one that is practical rather than technical. Statutes on the same subject matter must be construed together in the light of each other so as to harmonize them, if possible, although they were passed at different times. In construing a statute, the consequences that might flow from a particular interpretation must be considered. 45 Cal. Jur. 2d, Statutes, §§ 114–122. The Court believes the correct construction of § 509.5 requires a finding that the grandfather clause adopted by the CYA is valid and must be applied in determining the suitability of the Yolo County Juvenile Hall.

In its inspection report of July 28, 1970, the CYA reported:

> "The Yolo County Juvenile Hall was built in 1948 when the county population was 41,688. The population has since grown to 90,000; however, this figure does not include the additional 12,000 transient students from Davis College.
>
> For the era in which it was built and the needs of the county at that time it was adequate. However, according to present day standards and the growing needs of a growing county, it is rapidly becoming obsolete. The building technically is considered to be in compliance with Youth Authority standards since it was constructed prior to the adoption of the standards. However, it has many deficiencies and these are listed below. These deficiencies are serious enough in themselves but the situation is compounded by the fact that the hall population is frequently over capacity. A large and more modern structure is needed and Yolo County should begin planning to construct a new Juvenile Hall."

During the hearings on petitioners' motion, Gilbert Negrette, a representative of the CYA testified. Mr. Negrette inspects Juvenile Halls, Day Care Centers and Group Homes in the area generally between Kern County and Oregon. His inspections are made under the provisions of Welfare & Institutions Code § 509 and include 33 Juvenile Halls. He last inspected Yolo County's Juvenile Hall in August 1972. He testified that the Hall was suitable for the confinement of minors *if* the maximum capacity of 17 was not exceeded and *if* Yolo County continued to make progress in remedying the sub-standard problems of the physical plant of the Hall.

V

CONDITIONS OF THE YOLO COUNTY JUVENILE HALL WHICH RENDER IT AN UNSUITABLE PLACE FOR THE CONFINEMENT OF MINORS

The Court has not attempted to recite all of the evidence adduced during the course of 10 days of hearing, nor does the evidence which has been summarized necessarily represent a balanced summary of the voluminous documentary and testimonial evidence which was received. The Court, however, has considered the evidence, inspected the Hall on April 3, 1973 and finds that it is not being operated and maintained as a suitable place for confinement of minors for the following reasons:

1. The population of the Juvenile Hall continues to exceed its rated capacity of one minor per sleeping room, or 17 persons. This capacity has been approved by two Chief Probation Officers of Yolo County and by the California Youth Author-

ity, but, despite the uniform acceptance of that rated capacity, admonitions by the CYA to stay within it, and an improved effort by respondents to comply with it, the rated capacity continues to be exceeded regularly. It was, for example, exceeded on 98 days during the 182-day period from January to July 1972. The Hall is a suitable place for the confinement of minors *only* if its rated capacity of one minor per sleeping room, or 11 boys and 6 girls, is not exceeded.

2. The school building is not suitable for regular school classes until such time as it is found, by proper authority, not to be a fire and safety hazard. The 1971 Juvenile Justice Commission Report found the building was inadequate "by all standards for an educational program, security, fire, safety and space allowed per child." More ominous, however, is the letter of the Woodland Fire Department to the State Fire Marshall (March 2, 1972) in which the school building was labeled "a fire hazard". No evidence to the contrary was offered by respondents.

3. The existing infirmary is an alcove of the kitchen to which ingress and egress must be through the kitchen. A procedure which requires minors with possible communicable diseases to enter the kitchen to visit the infirmary is unsanitary. It is true that the food consumed by the minors is prepared at the Yolo General Hospital, but it is delivered to the Juvenile Hall kitchen and served from that kitchen. Moreover, some minors use the kitchen to prepare food in Home Economics courses and to make "snacks."

4. Within 48 hours after admission, each minor should be examined by a nurse or a physician.

5. The Hall should be inspected by the Yolo County Public Health Department at least once each month. The inadequacies of the Hall, both in size and layout, require that special effort be made that facilities and practices meet an acceptable standard of sanitation.

6. Forty hours of in-service training are not given to new Group Supervisors before they are assigned responsibility for supervising children. The CYA guidelines require that "New employees shall have a minimum of forty hours in-service training before being given responsibility for supervising minors." In its Report of Inspection dated July 28, 1970 the CYA recommended that "the staff receive a minimum of forty hours of in-service training before given responsibility of supervising minors." The evidence shows that this standard of in-service training has not been followed uniformly.

VI

REJECTED CONTENTIONS OF PETITIONERS

Petitioners' contentions suggesting the unsuitability of the Juvenile Hall were numerous. From its comments in the preceding section, it is obvious that the Court finds merit in some of their contentions. The Court also finds some of their contentions are without merit. Several of the rejected contentions deserve comment.

The program of the Juvenile Hall was attacked at length by petitioners. It is true that the existing program could be improved in many respects. However, the Court believes, as the Juvenile Justice Commission found in its report of April 12, 1971, that many of the deficiencies in the program of the Hall stem from the inadequacies of the building in which it is housed. Petitioners suggest, for example, that the indoor recreational facilities are inadequate and allow no physical exercise on rainy days. The opportunity for physical exercise on rainy days is limited and an indoor gymnasium or recreational facility, as petitioners suggest, is a desirable solution. Within the limits of the existing building, however, little indoor recreational activity can be permitted which is not already allowed.

Respecting the school program of the Juvenile Hall, which was much criticized by petitioners, the Court refuses to regulate that program. Under the provisions of Welfare & Institutions Code § 856, the school program is the responsibility of the respective school districts in which the Hall is located. The governing boards of those districts have not been served, are not parties to this proceeding, have not had an opportunity to be heard and the Court, therefore, declines to consider the school program.

It is true that the Policy Manual of the Juvenile Hall is out-of-date, and, in fact, is so out-of-date that it was either unknown to or ignored by one or more Group Supervisors. The CYA standards provide that "The County Probation Officer and the Juvenile Hall Superintendent should develop a policy statement defining functions, procedure and responsibilities involved in the operation." Acknowledging that a revision of the Policy Manual is overdue, the Court declines to find the Juvenile Hall "unsuitable" by this omission. The Hall must be judged by its actual functioning rather than by its stated objectives or policies.

Finally, the petitioners charge that the training and qualifications of the staff of the Hall are inadequate. By its comments in the preceding section, the Court has concurred that forty hours of in-service training consistently have not been given to Group Supervisors before they become responsible for supervising children. The Court does not, however, concur with petitioners' further criticisms of the qualifications and performance of the staff. As in the conduct of all human affairs, there have been some lapses and errors on the part of the staff, but given the cramped and poorly laid-out facility in which members of the staff operate, and the lack of support and understanding which the Juvenile Hall and its program have been given, the Court will not fault them. The need is for better facilities and broader support and development of Yolo County's juvenile delinquency program, not new staff personnel.

The Court hereby gives notice to the Director of the Juvenile Hall of Yolo County, the Probation Officer of Yolo County, the Juvenile Court of Yolo County and the Board of Supervisors of Yolo County, pursuant to the authority of § 509 of the Welfare & Institutions Code, that the Juvenile Hall of Yolo County shall not be used for the confinement of minors after June 29, 1973 until such time as the undersigned Judge finds, after reinspection of the Yolo County Juvenile Hall, that the conditions described in the preceding section V hereof have been remedied and that such Juvenile Hall is a suitable place for the confinement of minors. Such reinspection will commence at 10:00 a.m. on June 29, 1973, at the Courtroom of Department One of the Superior Court of Yolo County, Woodland, California.

Dated: April 24, 1973.

WARREN K. TAYLOR,
Judge of the Superior Court.

SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR YOLO COUNTY

STATE OF CALIFORNIA, COUNTY OF YOLO, SS, NO. 5326, CERTIFICATE OF MAILING

I, the undersigned, certify under penalty of perjury that I am a Deputy Clerk of the above entitled Court, and not a party to the within entitled action; that on April 24, 1973, I served true and correct copies of the foregoing memorandum Decision and Order by depositing them, enclosed in sealed envelopes with postage thereon fully prepaid, in the United States Postoffice at Woodland, California addressed as follows:

Hecht, Wald & Walker, Attorney at Law, Youth Law Center, 795 Turk Street, San Francisco, Calif.

Charles R. Mack, County Counsel (2 copies), Room 306—Courthouse, Woodland, Calif.

Hon. James C. McDermott, Judge of the Juvenile Court, Room 302—Courthouse, Woodland, Calif.

Mrs. Barbara Kendrick, Juvenile Justice Commission, 536 Anderson Road, Davis, Calif.

Mr. Austin Bryant, Director, Yolo County Juvenile Hall, 218 West Beamer Street, Woodland, Calif.

Mr. Leroy Ford, Chief Probation Officer, Yolo County, 218 West Beamer Street, Woodland , Calif.

Roger A. Sans, Attorney at Law, 609 Court Street, Woodland, Calif.

At the time of said mailing there was regular communication by United States Mail between the said place of mailing and the places so addressed.

Dated: April 24, 1973.

MILDRED SANDERSON,
Deputy Clerk.

Mr. SANDMANN. My name is Peter Sandmann. I am also an attorney with the National Center for Youth Law. I'll be talking briefly this morning, Senator Cranston, about what are euphemistically called training schools. These are, what you might call, junior prisons or places where delinquent children are placed by juvenile courts.

Not only are the children placed there for the commission of crimes, but quite often children are placed in these institutions because of such noncriminal acts as running away from home or truancy from school.

In the past 8 to 10 years, many of these institutions have been the subject of litigation which has resulted in disclosing a number of abuses which take place inside these institutions and these, of course, are institutions run by State agencies. They are not private institutions. There are no licensing problems with these institutions. But the abuses take place, nevertheless.

Some of the abuses that I've become acquainted with include such things as whole wings inside these institutions being set aside for solitary confinement purposes. Juveniles who commit some infraction of the institutional rules may be placed in these solitary confinement cells for days or weeks or even months at a time. In those cells, they're permitted no visitors at all. They have no reading material. They have no personal possessions with them whatsoever. And in one case in a large boys' institution that I'm familiar with, the only thing that they were allowed to do was that they were forced to engage in hard labor using a pick ax on the ground outside the facility for hours at a time during the day.

In that same institution, the punishment for refusing to work at hard labor was that several boys were put back into their solitary confinement cell and then a tear gas canister was thrown into the cell with them as a punishment for refusing to work.

Senator CRANSTON. Where did this occur?

Mr. SANDMANN. In Texas. It is, in fact, documented in the decision of the court. The court refers to these incidents in its decision.

In these same institutions, not only in Texas but elsewhere, physical beatings by the correctional officers, by the guards, are very common indeed. Guards use not only their fists and knees and feet to hit and kick the boys but also guards have been known to use broom handles and rubber hoses and things like that.

In the training school in Texas, to which I just referred, in a case that I worked on rather extensively, the guards would segregate the boys in the dormitories not only according to race but also according to alleged homosexual tendencies. We're talking now about dormitories that hold 30 or 40 boys at a time in open, huge open rooms with beds lined up row after row. There are no private rooms at all. The only night-time supervision for those dormitories were so-called night men that were hired. They usually were farmers, in the case of that institution, who farmed during the day and this was literally moonlighting for them. And they saw no obligation to even stay awake during the night to supervise the boys. They were just there in case of some emergency.

Boys would be placed into these dormitories regardless of their offense, that is boys who were in the institution for truancy or for violent offense were indiscriminately placed in the same dormitories.

The litigation that has exposed these abuses in many States indicate that these are not isolated incidents of simply a few institutions and a few isolated places or a few guards who behave like this, but that these abuses are very widespread indeed. Cases that I know of, for example, have taken place in Puerto Rico and Rhode Island, Indiana, Utah, Tennessee, Illinois, New York, Montana, other jurisdictions as well.

The abuses that we're referring to take place in institutions that are not designed for punishment. That is, the State law in each case requires that these boys and girls be treated, that they receive care and treatment, not punishment. The purpose of the institution is so they can become productive members of society, at least that's the purpose that the law sets forth.

I think that the reason for some of these abuses perhaps can be explained by both the size and location of the institutions in many cases. For one thing, the institutions are very large indeed. Even though the State law may say that the delinquent youth are supposed to receive care and treatment in what is called a homelike environment, in fact, the institutions may have from, anywhere from 50 to as high as 1,000 juveniles in an individual institution. In California, for example, we have two institutions run by the California Youth Authority that have about 1,000 boys each. One of them, the youth training school in Chino, Calif., I think has about 1,200 boys in it at any given time. These are obviously not homelike environments.

The other thing is that the rural location of many of these institutions almost dictates that they're going to have problems with them. The juveniles are quite often, more often than not, from urban settings and the staff is recruited locally and is very unfamiliar with the kinds of problems that are faced by these urban juveniles. Quite often the juveniles are from minority groups and the staff usually is not. Not only that, but in these rural settings, it's very hard to recruit highly trained professional staff so that the staff is quite often, as I suggested before, perhaps farmers or other people who do not have any special training at all in dealing with the problems of youth. Not only that, it's also very difficult in these rural settings to use community programs such as community mental health centers or private social service agencies that would be available in an urban setting. Those programs simply don't exist and can't be used by these institutions.

Finally, the institutions very rarely receive visits from the families or friends of the children involved. They're so far away from the homes of the juveniles that it's almost impossible for them to visit. In fact, it's almost surprising how many of these institutions have had abuses come to light through litigation and through investigations over the last several years. But it's clear that there are many more abuses in institutions which have not come to light. There simply aren't enough people looking into these institutions to know what may be going on.

I think that as a result of these problems with the institutions, including the large size and the rural locations, a kind of an aura is created, inside the institutions that it is almost impossible to correct. In fact, in the case in Texas that I referred to, the judge there decided that two of the institutions that we were litigating about had to be closed, and I'd like to read very briefly from the judge's decision. He said:

> The court finds, from the heavy preponderance of the evidence, that two institutions, Gatesville State School for Boys and Mountain View State School for

Boys, are places where the delivery of effective rehabilitative treatment is impossible and that they must not be utilized any longer than is absolutely necessary as facilities for delinquent juveniles. The uncontradicted testimony of children who had been confined at Gatesville and Mountain View, as well as the observations of the experts who visited those institutions, revealed a bizarre subculture that holds both inmates and staff in its sway. Rituals and codes of conduct are in existence which are as grim as the Sicilian Omerta all imposed on children, some of whom are no older than 12 years of age.

I'd like to say in closing, Senator, that these lawsuits, as I suggested, have only exposed the tip of the iceberg, and I believe, and I think the rest of us believe, that there are many, many thousands of juveniles who are suffering these abuses today and about whom we don't even know, about whom we don't know the details.

I think the next speaker will perhaps speak to some of the possible remedies for these abuses.

Senator CRANSTON. Thank you very much. Our endeavor is to find, among other things, the remedy. Thank you very much.

Mr. BULL. Senator, my name is Peter Bull. I'm also with the National Center for Youth Law.

What you have heard so far, I think, shows the need for some sort of effective monitoring system. But it also shows that monitoring systems are very difficult to achieve. For example, the two things that you've heard about this morning, if you were to look through the State licensing law in the Community Care Facilities Act in California and if you were to read the regulations that have been issued under that act, I think you might be quite impressed with what appears to be on paper a very good system of licensing and monitoring and requiring a diagnosis of each child and a plan for the child's care. It is under those provisions of State law that facilities such as Oak Creek Ranch and the other facilities you've heard about have continued to exist even after the conditions have been brought to the attention of the various people whose job it is to insure that that kind of thing will never happen.

Bob Walker mentioned to you some of the conditions of juvenile halls. California juvenile halls are required to be inspected, not only by the California Youth Authority, which has the power to close them down if any deficiencies are noted, but it must also be inspected annually by the Juvenile Court Judge of the county and also by the Citizens Commission known as the Juvenile Justice Commission. So you have three levels of inspection mandated by statutes and yet the conditions persist. What this means, it seems to me, is that, first, of course, I think it underscores what another witness said in response to your question that there is a terribly important role for the Federal Government to play in this because of the fact that an enormous amount of Federal money is used to support some of these types of institutions. And, second, whatever can be done in that regard, it is going to have to be a very strong sanction indeed in order to provide motivation that obviously is not provided simply by having what appear to be very good State licensing and monitoring laws.

The final thing that I wanted to mention was that I think that in addition to monitoring systems and even in addition to a get-tough policy in terms of Federal funding is, I think there have to be provisions requiring access by children and by their parents to independent advocates. I don't think that any system that's ever been devised is ever totally self executing or that people with whom one does not have a close and loving relationship are ever going to be protectable by people on salaries even if case loads are reduced. There has to be access to advocates.

The women who spoke this morning before our panel who gave such powerful testimony are model advocates. But, unfortunately all parents cannot function as they have done. You have heard the stories about the fears that parents have about what will happen to their children if they make complaints and although parents can organize together for systemic reforms and have done so, it is very difficult for them to act on behalf of their individual children because of the fear of retaliation. Furthermore, many of the parents of institutionalized children have been told by courts that they are failures. They have been officially labeled as failures and, therefore, need not be paid any more attention to. And others feel that way even though they have not been told that officially.

The example that you heard earlier of the myth that autism is caused by some mishandling. There is a tremendous guilt laid on parents in that regard so that they are in some ways unable to function as effective advocates. And we're talking here about children also who, when they're in institutions and when they're in foster care, really don't have any parents or their parents supposedly is the State or the county which is no parent at all. So that they're in no position to advocate for themselves.

The young men who were described by Abigail English, Mr. Smith and Mr. Bradford, are exceptions to this who, when they reached their late adolescence, somehow managed to find counsel and try to do something about it. By that time it was too late.

So one proposal that I would have in terms of legislative reform, and there are models for this, is that when Federal funds are allocated for the out-of-home care of children or indeed for any children's services, that those Federal statutes should include a mandatory allocation of funds for independent advocates. We have this already now under the Developmental Disabilities Act. Every regional center is supposed to have an independent protection and advocacies service which is completely independent from the other service providers. But, unfortunately, some of the things you heard about this morning have occurred even under that Federal legislation because the States, particularly the State of California, has evaded that requirement, apparently without any consequence of losing Federal funding.

I have submitted to Susanne two pieces of written material which I hope might be included in the record.

Senator CRANSTON. Yes, it will be.

Mr. BULL. One of them is an article from Federal Probation about a demonstration project where legal services were made available to inmates of institutions for juvenile offenders in the State of Minnesota and where it was discovered, after this one year, that almost one-half of the children in the institution actually had legal problems apart from the fact that they were being institutionalized. And a good many of those complaints were of physical abuse as well as complaints about some of the more subtle things. The conclusion of that article was:

> That no group of consumers are more in need of advocates and counsel than young people who are the wards as well as the responsiblities of the state.

And the bottom line on the article was that the project was defunded after a year and the author says it fell victim to some growing feeling within Government circles that the State should not fund legal services which might take action against agencies of the State.

The other thing I submitted, Senator, is a paper prepared by our office which discusses, in some detail and with statistical references, some of the needs that children and their parents have for advocacy services.

I want to thank you on behalf of my colleagues for the opportunity to speak here today.

Senator CRANSTON. If you'd wait one moment. I do have one question I would like to ask you, Mr. Sandmann.

First, I want to thank you for your very helpful testimony, for your directness and for your brevity. We will probably be submitting some questions for written answers, including soliciting your views on the legislation that we're working on.

Mr. Sandmann, Birch Bayh, a Senator from Indiana, is particularly interested in one aspect of this and I'm asking this basically on his behalf. The Justice Department participated in several of the cases that your program has been involved with on behalf of institutionalized children. Can you describe briefly the role of the Department of Justice in your litigation and the importance of the participation of the Justice Department in cases like this?

Mr. SANDMANN. Yes, Senator. I should have referred to the Justice Department earlier. You're referring to, I believe, what's called the Office of Special Litigation, which is within the Civil Rights Division of the Justice Department. That office has assisted, not only our office, but a number of other public interest lawyers in litigation regarding not only state training schools but also mental hospitals and hospitals and State schools for the retarded as well. I can say, not only from my own experience, but also from the experience of working with other lawyers and what they know about the Justice Department role, that it has been essential to have the Justice Department participate. Without the assistance of that Office of Special Litigation, I can say that many of these cases would not have been as successful as they have been and many of these abuses would not have been disclosed as they have been.

I know that Senator Bayh had introduced legislation last year to authorize the Justice Department to continue in this litigation and I very much hope and feel that it's extremely important that that legislation do get enacted in the coming session of the Congress.

Senator CRANSTON. Thank you very much. Would you give us in writing your thoughts in one other matter. The court, as I understand it, appointed an ombudsman in the *Morales* case to deal with continuing problems in the Texas Youth Council facility. If you could describe for us how this worked and whether you feel that that's an effective approach in dealing with institutonal abuse, that would be very helpful.

Mr. SANDMANN. I'd be happy to that, sir.

Senator CRANSTON. Thank you, each of you, very, very much.

[Material referred to by Mr. Bull appears in the appendix:]

Senator CRANSTON. We'll now go to the third of our four panels I'd like to ask its members to come forward. We have Michael Dale who is the former director of special litigation unit, New York City Legal Aid Society; Margaret Brodkin, executive director of Coleman Children and Youth Services, San Francisco; and Saul Wasserman, M.D., chairman, Child and Adolescent Committee, Northern California Psychiatric Society, San Jose.

Please proceed in whatever order you wish.

STATEMENT OF MICHAEL J. DALE, ESQ., ATTORNEY, NEW YORK LEGAL AID SOCIETY; SAUL WASSERMAN, M.D., CHAIRMAN, CHILD AND ADOLESCENT COMMITTEE, NORTHERN CALIFORNIA PSYCHIATRIC SOCIETY; AND MARGARET BRODKIN, EXECUTIVE DIRECTOR, COLEMAN CHILDREN AND YOUTH SERVICES, A PANEL

Mr. DALE. Thank you, Mr. Chairman, for inviting me to testify before this subcommittee.

My name is Michael Dale. I am currently the director of the San Francisco based juvenile justice legal advocacy project, which is a program funded by the Juvenile Justice and Delinquency Prevention Office within LEAA.

I appear before you today not on behalf of that organization but rather to express to you some of the views that I have gained over the past 8 years as a legal aid lawyer in the State of New York representing children, and I think that what I can bring before you, and what I have described in my written statement are, instances and descriptions which are quite similar to what you've heard expressed by prior speakers concerning circumstances in the State of California.

The written statement which you have is a sparse, and, I hope, dispassionate recitation of a long series of lawsuits brought in New York State on behalf of neglected and abused children, status offenders and delinquent youngsters. However, I think that it would be helpful to you and to the subcommittee if I describe some of the incidents, some of the examples of events that occurred and formed the basis for these lawsuits. It is quite hard to be dispassionate about what has gone on in New York State. It is heart wrenching to describe the events to you.

One of the lawsuits which we undertook in New York concerned an institution known as Children's Center, which was a large temporary shelter located in the borough of Manhattan on Fifth Avenue and 104th Street where neglected and abused children were theoretically kept for a short period of time, no longer than 3 months. It was a facility which could house 350 children and which did house at the time the lawsuit was commenced approximately 150 youngsters. The cost at that facility was somewhere in the neighborhood of $300 a week per child. There was a staff of 350 people looking after 150 youngsters.

That facility, as a result of litigation, was closed. The Federal judge hearing the case remarked when he learned that the cost was several hundred dollars a week per child that he felt they would have been better housed and perhaps less expensively housed in the Waldorf Astoria Hotel.

Some of the incidents that occurred there involved repeated rapes of retarded youngsters, specifically one retarded youngster homosexually raping another, then being taken by staff before his peers and being required to describe the rape to his peers. It involved instances where staff members were fired for engaging in sexual activities with youngsters. There was an incident where an adolescent girl was attacked on the roof of the facility and a broom handle inserted in her vagina. There were instances where several severely retarded youngsters resided at the facility for better than a year. Drugs and liquor were imported into the facility in an ingenious manner using a pulley system up to the fourth floor outside the facility, and I want you to remember this building is in the middle of Manhattan. Pimps had free access to the facility. Youngsters were raped in Central Park, which is in close proximity to the facility. And the instances go on and on.

I interviewed, prior to the commencement of the lawsuit, perhaps 50 youngsters who were residents there. One of the most troubling things that I discovered during the interview process was that when I reinterviewed a child who had been there for an extended period of time, the gleam in the child's eyes which I saw initially, after two or three or four months, was gone. The child's values had changed. The child had been part of an institutionalized subculture and in my layman's opinion in this area, the child was destroyed. The child was no longer alive in a way that I understood. I found that shocking.

We were involved in a second lawsuit concerning conditions in New York State training schools for status offenders, facilities not unlike those described by Mr. Sandmann of the National Center For Youth Law, previously. We found that there were a wide variety of activities and actions which can be described in no other way than shocking. For example, the residents at the State training schools—four of them with a total number of 600 children—often engaged in an activity of self-tatooing in which they would use magic markers or other kinds of pens to press below their skin, the coloring from the ink of the pens, to devise various tatoos. It was common practice in these institutions.

We found that children hated the facilities so much that there were endless escapes averaging, in a 60-bed facility, in one instance, over a 6-month period 30 escapes a month. We found that there were instances of institutionalized racism. For example, Hispanic youngsters in one of the facilities were not allowed to speak Spanish even though they came from families where that was the native tongue. In fact, in one of the institutions there was no Spanish speaking staff member despite the fact that about a quarter of the youngsters were Hispanic. We found an amazing lack of any kind of outdoor recreation. At one facility that I visited on six occasions over a 3-month period, spending a day there each time, I never saw a child outdoors playing. Not once.

The instances of brutality go on and on. However, you have asked that we describe to you certain remedies that we might feel advisable. In my statement I mentioned that I think that monitoring is extremely important and that monitoring, as a result of court case litigation, is difficult. Therefore, I would reaffirm what I heard an earlier speaker, Mr. Bull, say with regard to independent advocacy groups as a mechanism for monitoring, that they be used as a tool inserted in Federal statutes as an element in the process.

And, second, I would suggest to you that we attempt to reorder some of our Federal statutes so that the emphasis is moved away from funding institutions, funding agencies that run institutions, and we seek to redirect our energies toward funding community based services.

Senator CRANSTON. Funding what?

Mr. DALE. Community based services so that children do not have to go away from home. There was a time when one, as a lawyer representing a youngster, had a variety of services that he or she could call upon such as a visiting nurse service, community social workers, church related people, people who could talk to the family, and work with the family in the community. My personal experience over the past 8 years is that those kinds of services do not exist any more. The dollars flow in such a way that it is in the interest of the agencies that hire what were the community workers, to now hire these people to work in institutions. And I suggest to the subcommittee that we reorder the process.

Senator CRANSTON. Thank you very much.

[The prepared statement of Mr. Dale follows:]

STATEMENT OF MICHAEL J. DALE, ESQ.
BEFORE THE SENATE SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT OF THE HUMAN RESOURCES COMMITTEE.

HONORABLE ALAN CRANSTON, CHAIRMAN

January 4, 1979
San Francisco, California

Mr. Chairman and members of the subcommittee, my name is Michael J. Dale.

I am an attorney and presently director of the San Francisco-based Juvenile Justice Legal Advocacy Project, a program funded by the Office of Juvenile Justice and Delinquency Prevention of the Law Enforcement Assistance Administration for the purpose of assisting in the implementation of the Juvenile Justice and Delinquency Prevention Act of 1974.

However, I do not appear before this subcommittee on behalf of that organization. Rather, I appear here individually and with the hope that a brief description of some of my experiences over the past eight years as a legal aid lawyer in New York state representing children in institutions will be useful to this subcommittee.

There was a time when New York was regarded as a pioneer state and an innovator in the area of childcare. It isn't anymore. It isn't a leader despite a massive system including the New York State Division for Youth, the state and local departments of social services and numerous large private agencies, which care for nearly 50,000 children out of the natural home. It isn't innovative despite the fact that highly regarded, principled professionals such as James Dumpson, Peter Edelman, Milton Luger, and Jules Sugarman have administered governmental agencies.

New York's most obvious failure in childcare has been in the area of children in institutions. One need not look to the institutions for the retarded or mentally ill youngster, such as that in the notorious Willowbrook case, N.Y.S. Association for Retarded Children, Inc. v. Rockefeller, 357 F.Supp. 752 (EDNY 1973), to see that large childcare facilities have not succeeded in New York. A brief look at the shelters for the neglected, detention facilities and training schools for delinquents, and training schools and forestry camps for status offenders, demonstrates that New York's failures are legion.

For example, in the summer 1976, the Juvenile Rights Division of the New York City Legal Aid Society filed a federal civil rights action entitled Darasakis v. Smith, No. 76 Civ. 3218 (IBW) (U.S. Dist. Ct., SDNY). This lawsuit was an attempt to force the closing of New York City's major temporary shelter, Children's Center, located in Manhattan at 5th Avenue and 104th Street between the Museum of the City of New York and Flower Fifth Avenue Hospital. Children's Center had operated as a shelter since 1958. It had a long and notorious history including numerous investigations, reports and administrative shakeups. At times its population was as high as 350. At the time the lawsuit was filed, 150 boys and girls resided there. Included in the population were children aged 11 to 18. There were several severely retarded youngsters. One had Down's Syndrome; several residents had severe physical handicaps. There were a number of angry, acting out, aggressive adolescent boys and girls. There were several runaways from other states and several girls who had just been released from psychiatric hospitals. The complaint recounted the sordid history of the institution, including several investigations and public reports criticizing the facility. The complaint discussed a large number of recent gang rapes, forced sodomy, beatings and frequent attacks upon the retarded youngsters. Another allegation described a particular activity in which girls at Children's Center would apply vaseline jelly to their arms and faces when fights were anticipated in order to make it more difficult to be grabbed and scratched. It was alleged that pimps had free access to the facility, that several girls were raped in Central Park and that others worked for pimps out of nearby apartment buildings. Furthermore, the staff was unable to contain the turmoil.

After the suit was filed the director of the division of the Department of Social Services responsible for Children's Center described it in television interview as "an awful place." Yet, at the time of the lawsuit, Children's Center had a staff of 350 and a yearly budget of over $3 million. The cost was almost $400 per week per child. At that cost, the federal judge hearing the case said, the children could have been housed at the Waldorf Astoria.

Children's Center is closed now. It closed nine months after the suit was filed. Much smaller group residences have taken its place as temporary shelters.

Until two years ago, New York City had a second major temporary shelter for neglected children and status offenders. The purpose of Jennings Hall, located in the Bushwick section of Brooklyn, was to house boys for a short period -- up to a maximum of 3 months, until an appropriate setting was found. In Dale v. Dumpson, 355 NYS 2d 485 (1974), I represented a severely retarded, physically handicapped fourteen year old boy who had resided in temporary shelter care for two years. At Jennings Hall, he was fed, clothed, and he attended the Shelter's school. He received no physical therapy, no special education, and no regular counseling. Rather, he was persecuted by other residents because of his physical maladies, suffering cigarette burns and other injuries. The staff of the institution was unable to give him appropriate care and treatment. The court case lasted a year and a half and went to New York's highest tribunal, the Court of Appeals. There, in an unprecedented ruling from the bench after an open vote of the justices, Chief Judge Charles Breitel ordered the defendant New York City Commissioner of Social Services to immediately locate proper long-term placement for the boy or be held in contempt -- two months later, appropriate placement was found. Dale v. Dumpson, (N.Y. Ct. App. Feb. 27, 1976).

Litigation was also brought challenging the use of training schools for status offenders, in McRedmond v. Wilson, 533 F.2d 757 (2d Cir. 1976). At the time the suit was filed, New York operated four training schools: Tryon, Brookwood, Hudson and Highland, housing a total of approximately 600 children. All of the schools were located either in rural locations or, in one case, on the outskirts of an upstate town. The training school nearest New York was 130 miles distant. The plaintiffs sued for the failure to provide adequate rehabilitative treatment, recreation, medical care, remedial education, community and family contact, and aftercare. None of the nearly 600 children in the facilities was an adjudicated juvenile delinquent. No evidence was available to show that these large institutions helped the children. Rather, after two years of litigation, and in reliance upon the implementation of the Juvenile Delinquency Prevention Act of 1974, the defendants agreed to remove all status offenders from the training schools.

The State of New York continues, however, to operate forestry camps to which status offenders are sent. Two of these institutions, Camp Cass located 40 miles southeast of Albany, and Great Valley Youth Camp, located 100 miles south of Buffalo, are the subject of pending federal litigation concerning forced labor. The case, entitled King v. Carey, No. Civ. 75-14 (U.S. District Ct., WDNY), is a class action based on the fact that the 120 residents of the two camps are required to work, clear forest land, ski slopes on state land, clear state roads, repair grave yards and work on waste disposal projects without any remuneration. Moreover, at neither camp is there on-site medical care.

New York's secure training schools for juvenile delinquents have also been the subject of a major lawsuit, in Pena v. New York State Division for Youth, 419 F.Supp. 203 (SDNY 1976). The charges in that case included massive use of solitary confinement, hand and foot restraints, and psychotropic drugs. After a federal court trial involving the testimony of a number of nationally known experts, including Fritz Redl, the court ordered severe limitations on the use of these devices. The process of monitoring compliance with the court order continues, more than two years later.

A final illustration is a case entitled Martarella v. Kelley, 349 F.Supp. 575 (SDNY 1972); 359 F.Supp. 478 (SDNY 1973), which involved conditions in New York City's secure detention facilities for delinquents. The federal court found that the three facilities involved in the case were maintained and operated in such a way as to constitute cruel and unusual punishment. Two of the facilities were closed. One remains open -- Spofford, with a population of just under 200. Numerous changes were ordered there, and an ombudsman program was introduced, but serious problems continue to crop up. No one seems to know what to do.

In summary, what one finds is a litany of litigation challenging conditions in a variety of large children's institutions in New York state. The cases have been successful in the sense that they prove that the facilities don't work and that alternatives are needed. However, they are not at all an efficient method of effectuating change in childcare. The law suits have been expensive. Monitoring and enforcing court orders are time-consuming and expensive in themselves. Judges are not anxious to tell state and local officials what to do. It would appear from the body of information introduced by experts testifying on behalf of the children in all these cases that alternative methods are available to help institutionalized youngsters. Similarly, the body of academic research supporting small community-based alternatives to insitutions is significant.

Therefore, I submit, legislation aimed at fostering alternatives to institutions, such as group homes, foster homes, crisis centers, drop-in centers, and multi-service facilities for kids with the availability of medical, legal, vocational, educational, social and recreational advice is urgently necessary.

Unless such legislation contains adequate appropriations, and other incentives favoring alternatives to large institutions, and unless the legislation is effectively implemented, children will continue to be damaged and demeaned in facilities such as those I have described, and lawsuits like those in New York will continue to be necessary.

Dr. **Wasserman**. Senator, I'd like to thank you.

As a psychiatrist, I've had contact with approximately over 500 children in the past 5 years. I've been a consultant for the probation department, for the youth authority, and I am now the director of a locked psychiatric ward where we see children after they have made suicide attempts, or become so aggressive that nobody can deal with them, or have had breakdowns. I've often vowed at some point I've wanted to speak my mind, both as a professional and as a parent, on some of these issues, and I've had to live with things for too long.

Senator **Cranston**. The time has come.

Dr. **Wasserman**. I'd like to list three things that I think contribute very significantly to the institutional abuse of children, rather than recount the abominations that you've heard earlier today, and connect them in a way I hope will be useful to you as a leader in our Government.

One is the failure to provide adequate staff supervision, training, and support. Now, that applies up and down the system whether we're talking about foster parents who are just given children and not prepared for the problems that those children are likely to have, to the facilities throughout the system, to the worker in the juvenile hall, to the worker handling a developmentally disabled child. It's a tough task. If you overload people, they react in violence and they react in a dehumanizing way. All of us are capable of reacting in a dehumanized way under enough stress.

The consequence of not providing adequate support for foster parents is an excessive number of "placement failures."

You've heard before, and I gave you in my written testimony, an example of a child who has been in 16 different foster homes over the course of 4 years. Senator, children are like trees. They do not transplant well. Each time a child is transplanted, he learns not to love, not to make connections, and not to form bonds with the other people around him. Charles Manson had lived, I think, in 18 different homes before he was 21. If we work at it, we can produce people who have no human bonding and have such bizarre behavior.

Second, overloading of institutions with either too many children or with children of such great need that staff capabilities are exceeded. You have heard testimony about the juvenile halls that are overcrowded. You have heard testimonies about the severe difficult problems that autistic children can present. As far as I know, the only way to deal with that is to supply people, and people means time and money and effort.

Third, I would list failure of governmental agencies to do their work in a timely or appropriate way because of budgetary or other pressures. Now, Senator, if I had to give the Government a grade, it would not be very good. In California I regret to report I have seen what I would consider to be a deterioration. For example, in California a study was done about licensing day care which is an important respite for some parents. It was found that the State was 2 years behind in its licensing. As a consequence, mothers who were on welfare were unable to place the children in day care facilities because the Department of Social Services would only fund licensed facilities. As a consequence, a collection of unlicensed bootleg facilities were developing, with no control over quality of care given children.

The real problem is not with the welfare mother who places her child in the unlicensed facility. The problem is with the State who doesn't have a competent, effective licensing supervision process.

Fourth, in California, Senator, the State hospitals have consistently failed to meet the minimum standards required by the Joint Commission on Hospital Accreditation. I refer you to appendix B about Sonoma State Hosptial. The failure of accreditation in State hospitals in California is, in my opinion, an abomination. Those are the minimal standards that any private facility would be expected to meet. As you have heard today, even if the facilities were to meet accreditation, it would not mean that they would be completely adequate. Governor Brown knows that those facilities have not met standards. Every member of the State assembly and State senate in California knows that they have major deficiencies. Now, I cannot act to remedy that deficiency. I can only see parents who know that their children need treatment but who are terrified at sending their children to facilities where they feel they will not receive adequate care.

Further, in California, as across the Nation, the courts have said that children with a criminal behavior or with mental illness should be confined in the least restrictive alternative appropriate with their clinical need. In California, both in Santa Clara and Sacramento Counties, needed residential treatment facilities for adolescents were being built to meet the need defined in these court decisions. The mortar and the brick were being assembled into needed programs. Now, in response to proposition 13 they have been put on hold for the indefinite future. The reason is that the funding situation in California is so uncertain for such facilities that every county is terrified about their own budget. I have seen children who were removed from institutions on the basis of 1 day's notice, Senator, because the counties were overwhelmed with their anxiety about proposition 13.

To sum up, I think that in California, at least in the Bay Area, children's physical needs, with the possible exception of some developmentally disabled children, are being met. In every juvenile hall the child will be fed. And I actually don't think that in many facilities children are being beaten or grossly physically abused.

I believe that the psychological needs of children are met episodically. They're met in some institutions and they're not met in others.

I think our task is twofold. One has to do with resources, the size of the pie that's spent for children's services. I see that slice shrinking, Senator, and I think that will translate into poorer care and poorer supervision for children in the future in California. The second has to do with how that available resource is used. Our current system is too remote, too rigid, too out of touch with the children that it serves as people. It's not flexible, it's not sensitive to the timeframe of the child, it's not tuned into the psychological world of the child, it's not responsive to the emotional needs of children.

I don't think the answer is necessarily Federal standards because, as you've heard, standards on paper don't mean anything. We need to sort of decentralize and open up our institutions so that we can rely on people which is, I think, the thing that really helps keep the system humane.

Thank you for your attention.

Senator **Cranston**. Thank you very much. I'm going to have questions in writing. There is one question I'd like to ask you. What mechanisms are utilized in the institutions where you work to monitor against abuse of children, and do you feel those would work in large institutions?

Dr. **Wasserman**. Senator, that is an excellent point. There are 16 children in the institution that I am director of, and I know each of those children by name. I know their problems and I know what is going on between them and the staff. My personal feeling is that an institution should not be larger than the size where the director could know the names of each of the children in it. I think that once you get big, you inherently start to develop bureaucratic strategies in terms of dealing with problems rather than human strategies. Centralization frequently leads to a deterioration in care rather than an improvement in care. Decentralization doesn't necessarily mean that care is good, but large institutions, I think, have a significant handicap right from the start.

Senator **Cranston**. Do you have any feelings about where the breaking point is, how large an institution can be and remain compassionate and responsive to individual needs?

Dr. **Wasserman**. Well, Senator, I think it would be somewhere about 50.

[The prepared statement of Dr. Wasserman follows:]

GOVERNMENT POLICY AND CHILD ABUSE IN INSTITUTIONS

In my work as Director of a locked psychiatric ward for children and adolescents and in my former work as psychiatrist for a county juvenile probation department and state juvenile correction program, I have seen many children living out of home in institutions. I will use the term "institution" to cover the range of foster homes, foster group homes, residential treatment centers, juvenile halls, prisons and psychiatric hospitals that are oriented towards children.

I have found most staff people in institutions for children to be sincere and compassionate in their feelings towards children. I have found this true in virtually every facility I have seen. However, I have seen that it is possible for this good will to be eroded by a variety of pressures. The staff response to these pressures is typically reflected in difficulties in the relationships between staff and children - typically underinvolvement and apathy, sometimes overinvolvement and a loss of professional perspective, occasionally overt outbursts of anger that lead to physical mistreatment.

I intend to focus on governmental policies that, in my view, tend to increase the risk of either physical or psychological mistreatment of children, by increasing the pressures on the staff working in institutions. I will present some specific examples.

1. Failing to Provide Adequate Staff Supervision, Training and Support

A. My neighbor was a foster parent for a child who had serious behavioral problems. During the two years that the child was in the home, the only support and guidance the foster parents were given was what they could bootleg from me. Their only contact with the placing agency was a crisis of such serious proportions the foster parents felt they could no longer keep the child in the home. As they put it, "We felt like they put our names at the bottom of the pile when it came to contact because we had a middle class home. Nobody told us what to expect and they didn't provide any help until it was too late." Their foster-child has been returned to the County Shelter. These problems lead to the type of placement history you see in Exhibit A, a record of the placements for a nine year old boy recently admitted to our unit. The child has been moved sixteen times in four years.

Children are like trees - they do not transplant easily and each time they are moved their growth is impaired. "Placement failures" are very damaging to the morale and spirit of children, but we don't do much to prevent them.

2. Overloading an Institution with Either Too Many Children or With Children of Such Great Need That Staff Capabilities are Exceeded

B. A fifteen year old girl on our unit was recovering from a psychosis. Because of administrative conflict between the County Conservator, the Department of Social Services, the Mental Health Bureau and the Juvenile Probation Department, we found it impossible to arrange funding for a clinically appropriate residential treatment center. As a stopgap measure, the child was placed in a group home with a much lower level of structure and supervision. The child soon ran away and wandered for several months. Fortunately she eventually returned home safely.

C. A unit in a juvenile hall found it necessary to cope with a group of children with a particularly severe range and depth of psychological disorders. Staffing is solely a function of numbers; county fiscal policy does not permit temporary additional staffing even though the unit recently experienced a riot.

D. Staff positions in a state hospital program for the developmentally disabled were not filled during a "freeze" as part of a governmental economy move. Staff morale deteriorated; a recreation therapist considering an improvement in the activities program abandoned the idea.

3. Failure of Governmental Agencies to do Their Work in a Timely or Appropriate Way Because of Budget or Other Pressures

E. In one county, a study of children in day care revealed that a substantial number of children were in unlicensed homes. Apparently, state licensing was two years behind in the licensing process and homes could not secure a license quickly. Since the Department of Social Services will not pay for children to be in unlicensed homes, mothers on welfare had particular difficulty securing day care for children so they could go to work.

F. In several states, including California, state mental hospitals have repeatedly failed to meet the minimum standards required by the Joint Commission on Hospital Acreditation. (See Exhibit B) If the state cannot keep its own facilities licensed, how can it seriously enforce minimum standards in the community? Why does the federal government continue to tolerate failure to bring institutions up to standard when it ostensibly is federal policy not to financially support non-accredited facilities?

G. Recent court decisions have emphasized the legal requirement that the mentally ill be treated in the least physically restrictive, but still clinically appropriate facility. With children, this has frequently meant the use of residential treatment centers in the community rather than locked state hospitals far from a child's home and family. Two California counties that were in the process of building adolescent residential treatment centers have had to cancel the projects because of post-Proposition 13 cutbacks. The inevitable consequence of the loss of these facilities will be more children in state hospitals and the undesirable use of juvenile halls, hospital emergency rooms and "downtown city streets" as the home for this group.

In summary, let me list again three major ways in which governmental policy leads to increased pressure on the staff of programs that deal with children - by:

1) failing to provide adequate staff supervision, training and support;

2) overloading institutions with either too many children or with children that exceed staff capabilities; and

3) failing to do necessary work in a timely or appropriate way because of budget or other administrative pressures.

My general observation is that the vast majority of children I have seen in institutions are getting their physical needs met. Some children in some institutions are getting their psychological needs met. I think we can do far better than we currently are doing.

The task is two-fold. One aspect has to do with resources - the size of the slice of the fiscal pie available for children's services. I am very distressed over the fact that we are seeing significant cutbacks recently. It seems quite likely that we will see a significant deterioration in institutional care in response to the current financial pressures.

The second part of the task is to make better use of the resources we have. My personal view is that our system has become too remote, too rigid, and out of touch with the children it serves as people. Somehow we need to develop programs more flexible and sensitive to the time frame of the child, more aware of the psychological world of the child, and more responsive to the emotional needs of children.

Saul Wasserman, M.D.

January 2, 1979

EXHIBIT A

PLACEMENT HISTORY OF MICHAEL

09-17-74	09-28-74	Ruthie	Emergency
09-28-74	03-21-75	Judy A.	Foster parent needed respite
03-21-75	03-28-75	Judy B.	Respite
03-28-75	05-23-75	Judy A.	
05-23-75	05-28-75	Judy B.	Emergency
05-28-75	06-11-75	Barbara	Emergency
06-11-75	06-24-75	Burt & Arlene	Emergency
06-24-75	07-17-75	Cynthia	Child out of control
07-17-75	04-19-77	Burt & Arlene	
04-19-77	06-03-77	David & Linda	Adoption did not work out
06-03-77	05-04-78	John & Carol	Out of control
05-04-78	05-31-78	Aletha	Emergency
05-31-78	06-09-78	R. Kent	Emergency
06-09-78	11-06-78	Boys Center	
11-06-78	Present	Burt & Arlene	Emergency

EXHIBIT B

Sonoma Hospital May Lose Federal Funds

Chron 12/23/78

Sacramento

Sonoma State Hospital is in jeopardy of losing its federal certification and nearly $1 million a month in federal tax support, but California's top hospital inspector said yesterday that "chances are" the facility will be up to standards by next week.

Deficiencies in the hospital pharmacy, kitchen, speech and hearing treatment, and medical staff organization have threatened loss of federal certification, said Don Hauptman, the licensing chief of the state Health Services Department and the man who will decide whether Sonoma is up to federal standards.

Hauptman said officials at the hospital believe they can remedy deficiencies by Wednesday.

"Chances are they are going to be in compliance," Hauptman said.

For more than a year, certification has been a major problem for many of California's 11 state hospitals. Some of them found their certification withdrawn along with federal financial support.

Sonoma State Hospital is the largest of the facilities designed to care primarily for the developmentally disabled, or mentally retarded. It has about 1800 patients.

If hospital officials report next Wednesday that deficiencies have been corrected, Hauptman said he will schedule an unannounced inspection to decide whether to approve certification.

Such an inspection last October revealed the deficiencies. The threat of losing certification apparently has grown since then, and last week state Health and Welfare Secretary Mario Obledo and Hauptman visited Sonoma State Hospital to check on progress.

Our Correspondent

San Francisco Chronicle 13
★ Sat., Dec. 30, 1978

Sonoma Hospital Gets More Time to Correct Hazards

Sacramento

Sonoma State Hospital will have another two months to remedy health and safety problems that jeopardize $1 million a month in federal funds, a state official decided yesterday.

The 2061-bed mental hospital had a Sunday deadline — the end of the year — but was granted a 60-day extension by Don Hauptman, chief of licensing and certification for the state Health Services Department.

Department spokesman Peter Weisser said Hauptman expressed confidence that the hospital would solve its problems long before the new March 2 deadline.

State surveys earlier this year found problems in the hospital's pharmacy, food service, speech and hearing areas, in cleanliness, distribution of staff, and overall safety.

Associated Press

Senator CRANSTON. Thank you very much.

Ms. BRODKIN. My name is Margaret Brodkin and I'm a clinical social worker. I'm the director of Coleman Children and Youth Services, an advocacy and planning organization started in San Francisco 3 years ago because of overwhelming community concern about what happens when a child enters the institutional system. That's what I want to talk about: The emergency response to a child which precipitates an emergency institutionalization. (Emergency institutions are usually called shelter care facilities.)

I want to make two points. One is that there are many children who get institutionalized who should never be institutionalized in the first place. This is because of inadequate resources in the community. And, second, once institutionalized in an emergency facility, the facility is inadequately prepared to really meet the needs of the child and to assess the child's problem. We feel that this gets a child channeled into the system and then very frequently inappropriately placed. This ends up compounding the child's problem rather than alleviating the problem.

It is a fairly sizable group of children that we're talking about. It is the way that a large percentage of children do get into institutions in the first place. In San Francisco alone, 63 children a month, that's new children, are brought into the institutional setting through emergency institutions. And this number has remained consistent since 1974, even though there is a decline in children's population in the city and even though there is a philosophical commitment to keep children in their own homes.

In addition, children are staying in these institutions longer than they were before, so that the average daily attendance has risen from 1974 from 41 a day to 58 a day. I recently reviewed all the admission slips for the past 6 months of children who are brought into emergency care. I think there is a public assumption that most of the children are brought in because their homes are grossly inadequate and they are physically abused. These are the kinds of cases that get a lot of attention. I found only three cases in the last 6 months of children who were brought in because of the kind of severe physical abuse that receives a lot of attention. The largest category (out of 10 categories) of children were brought in because an overstressed mother temporarily left her child with either a grandmother, babysitter, or other caretaker who no longer wanted to care for the child. Thirty children alone were brought in simply because their mothers were hospitalized.

We feel very strongly that the kind of in-home community support services that could buttress the family and prevent a child from entering the institutional system are not available. Very simple things like emergency day care, therapeutic day care, respite service, emergency homemaker's services have been shown that when implemented, cut institutionalization in half in just a few years. These services are not available in San Francisco. As a result, a lot of children enter the system that never need to enter the system in the first place.

Another reason these children get into the system, we feel, is because the wrong people go out to assess initially whether a child needs to be institutionalized. Almost 50 percent of the children are brought in by a line policeman who really doesn't have the skill or the time or the expertise to evaluate whether a child needs to be institutionalized. If there were 24-hour, on-call social workers or trained people who were skilled in utilizing services or assessing welfare of children available, this might not happen.

We feel that once a child is in an institution, there is an assumption that all the forces in the system will work to get the family on its feet again and put the mother and her child together. This really doesn't happen. Once a child is put into an emergency shelter, the crisis is over for the policeman, it's over for the welfare worker. Two thirds of the children will stay there up to 2 and 3 months. This includes children for whom there has been no need for institutionalization other than their home environment or somebody's subjective impression of their home environment. The energy of the system then goes not into serving the family but evaluating whether this is a good case or a bad case to bring to the courts. About half the cases then are brought to the courts.

What happens once a child is in the institution is that for a period of 2 or 3 months the child rarely sees his natural family. If the child is under 6 in San Francisco, family visiting is only allowed 1 hour a week. This is not because the people are abusive or uncaring who run the institution. It's simply because of lack of staff and lack of transportation. What that means is that a child who is waiting to see whether they should or should not be returned to his family only sees his mother 3 or 4 times during a 1-month period.

I sat in on a hearing of a 15-month-old child who was returned to the mother. The child had been the victim of several accidents in the home and the police had a question of whether the accidents were negligence on the mother's part. It was determined that the child should be returned to the home. But the child went through 3 months of living with strangers and seeing the mother only an hour once a week. This is a child who is in the throes of stranger anxiety. Most children this age don't even want to be held by people other than their immediate family. We believe that constitutes a kind of institutional abuse of children.

From the way the institutional shelters are structured, the separation of the family is reinforced. This happens not only by the visiting regulations but also because it is no one's therapeutic responsibility to ever sit down with the child and with the parent together. One staff of people talks to the children; other social workers and probation officers talk to the parent. Nobody talks to them together. Therapeutically this makes no sense in doing an assessment of whether a child should return home.

The staff members who are expected to treat a child in an emergency shelter are not the people who are making the decisions about the child. They are left with the child in limbo for 2 or 3 months and they themselves are in limbo. It is the social worker and the probation officer who must make a decision about what will happen to the child.

The shelter care staff tells us that children receive visits from their social workers and probation officers maybe two or three times the whole time they're in these institutions. This is hardly adequate to make an assessment about what is in the best interest of the child. The shelter care staff members themselves are nice people, but they're not adequately trained or supervised or get the kind of support that we've been talking about to respond therapeutically to a child in crisis who has suddenly been taken away from any familiar surroundings.

What happens to a child on his first day in shelter care illustrates this. The child is maybe shuffled between three or four different agencies and different personnel and is finally left literally on the doorsteps of the shelter care facility. Most of the time the staff, who must then treat the child and respond to the child's need, is given almost no information about the child. About 50 percent of the admission slips say simply "child needs shelter," and that is what the staff then knows about that child. That's the information they have in trying to help the child work through this terribly traumatic thing that's happened to the child.

We believe essentially that the whole child welfare system has to be turned upside down, that resources and energy and control need to be allocated and put at a family's entry into the system. The way the system is set up now, it's very easy for children to get inappropriately involved in the system and then funneled through the system.

Shelter care facilities vary in how well they're run. We have a boys' facility here that is well run. It houses children from 7 to 17. It has 20 beds. Because of the age range and because of the wide variation of behavior they must deal with, it has to be fairly structured. It has a rigid time structure and rather rigid house rules. This is very appropriate for some children and totally inappropriate for other children. When you get a child that doesn't fit into the system, the only alternatives the staff have are to send the child to juvenile hall or send him to a psychiatric ward. It's easy to see that once a child comes into this system and may not fit into this particular shelter, he might end up in a psychiatric ward. In this way, he suddenly becomes a part of an institutional system in a case where it may not have been necessary to be in shelter in the first place.

We feel that one of the answers is to allocate resources at a family's entry into the system. This alone could alleviate many of the problems that occur later on.

Senator CRANSTON. You've indicated that on the first day of emergency institutionalization in San Francisco, the child will be taken to four different places or facilities by three different workers. Would you describe what that situation is briefly?

Ms. BRODKIN. The child may be picked up by the police, then taken to the youth guidance center where he will see his probation officer. Then he will be taken to an intermediary facility where a different worker will take him to an emergency room. There he will have to wait up to 3 hours for a medical clearance. Then he will be taken to the emergency facility where he will actually be placed. The process usually takes a whole day. Very frequently children arrive at these emergency facilities unfed and totally bewildered.

Senator CRANSTON. What would you do to streamline that procedure or to change it?

Ms. BRODKIN. I think there should be 24-hour coverage by the Department of Social Services. The Department of Social Services should have the power to go out and respond immediately to a child. The police should not have to go out, the probation officer should not have to go out. The social worker should go out, to use their expertise in evaluating what is right for that child.

Senator **Cranston**. Is it your understanding that that type of San Francisco situation is fairly typical of what appears across the Nation?

Ms. **Brodkin**. I think it's probably pretty good.

Mr. **Dale**. Senator, if I may, it is similar to the situation in New York City.

Dr. **Wasserman**. One solution to that problem, Senator, is to just have the child placed with an emergency parent and separate out the legal issues involved in. Is the child a dependent or nondependent, rather than confusing the legal issues regarding the appropriateness of the child's being taken into a dependency status from the child's psychological need. There is an enormous amount of evidence suggesting that children, particularly very young children, handle separations very poorly and, in fact, one of the classic psychological studies that has been done about a 2-year-old going to a medical hospital with orthopedic needs. A normal child in a normal family and the devastation that that hospital experience had on that normal child. So that these multiple separations are extremely damaging, especially to young children.

Senator **Cranston**. Thank you very much.

Mr. Dale, would you just briefly, so we have it in the record, define the term "status offender"?

Mr. **Dale**. It means a youngster who has committed an act which is not delinquent, that is if he or she were an adult it would not, generally speaking, contravene the criminal code, but it contravenes a law that applies only to children and specifically would mean that the child was beyond the control of the parent, was wayward, was truant from school, was uncontrollable in a given situation or was a runaway.

[The prepared statement of Ms. Brodkin follows:]

Senator CRANSTON. Thank you. I would like to ask you now one question for answering in writing to us, if you would. Do you feel that the Ombusman program at the Spofford Institution in New York has been a benefit in reducing problems with that institution and, if not, why hasn't that worked well?

Thank you very much. You have been most helpful.

We will now go to our final panel. I would appreciate it if the members of it would come forward. Marty Roach of Project Concern, San Francisco; Kathy Baxter, Prevention of Abuse and Neglect of Children in Out-of-Home Care project, San Francisco Child Abuse Council; Steven Pechter, Children's Advocacy Center, Oakland; and Patricia Apkaw, Urban Indian Child Resource Center of Oakland.

It's now 12:25. We have to quit at about 1:10 so if you can follow the fine example of those who were just before us and be succinct and direct to the point. Your full statements will go in the record and I may have some questions in writing if I don't have time to ask them verbally of you.

Proceed in whatever order you see fit.

STATEMENTS OF MARTY ROACH, PROJECT CONCERN; KATHY BAXTER, PREVENTION OF ABUSE AND NEGLECT OF CHILDREN IN OUT-OF-HOME CARE PROJECT, SAN FRANCISCO CHILD ABUSE COUNCIL; STEVEN PECHTER, CHILDREN'S ADVOCACY CENTER; AND PATRICIA APKAW, URBAN INDIAN CHILD RESOURCE CENTER, A PANEL

Ms. ROACH. My name is Marty Roach and I'm representing Project Concern, which is a non-profit organization formed to improve the care that children receive in out-of-home placement.

I want to testify today on a study that was done by the project this last summer, which you have a copy of. It's a survey of group home public files that were maintained by the Department of Social Services, Licensing and Certification Division. These files are mandated by law and they contain information about each facility's program. This includes staffing patterns, program philosophies and most important, they are supposed to contain inspection reports which are reports that have to filed annually when the licensing worker goes out and inspects a program to be sure that it's in compliance with the community care regulations.

Before I summarize the research findings and the recommendations, I'd like to explain some of the background factors that led to the reason we did this study. As we heard a lot today, children in placement are exposed to a lot of hazards. Many of the problems, like fires in facilities that don't have fire clearance, poor sanitary conditions, neglect and even some physical abuse, could be detected theoretically by the licensing agency if it was enforcing the community care regulations. Although California has a very good licensing statute that was implemented in 1975, there have been repeated studies, primarily by government agencies, that have shown that licensing is operating substandard. There have also been studies, which I have documented in the report, which show also that the care in facilities, in many cases, is substandard, and I think a lot of the testimony you've heard today has corroborated this.

There have been many organizational changes in licensing but it appears that licensing is still operating inefficiently. Because of this, we decided to try to monitor how licensing was working. We were interested in monitoring group home facility files because we saw these as one place for public access into how pre-home placement would be operated. We ran into an immediate problem because although the law very clearly states there has to be public information, neither the local agency nor the higher administrative levels could tell us what was supposed to be in these public files. When we actually looked at the files, they were often a mess and it was hard to make much sense out of them. In many ways they were pretty useless.

We went through laws and regulations and also through operations memos within the department and from that we pulled together what should have been the policy for public information of these files. We then surveyed 42 children's group home files to see if this information was, in fact, on file. I just want to briefly state some of the major findings of our report.

From the 42 group home files, there should have been 581 public documents. These are anything from the actual license which tells what the facility is licensed to do and how many children it can take right on through staffing reports that show they have properly trained staff through to the inspection reports which I mentioned earlier. Out of the 581 documents that were supposed to be in the files, 333 were missing. This is well over half. Seven of the forty-two files that we surveyed had had no indication of a fire clearance in over 3 years. Eleven of the group home files we looked at showed no indication that there had been a public inspection by a licensing worker in over 2½ years. There were also 29 items in the files that were clearly confidential information. I think some of the most serious violations of confidentiality involved times when there were names of complainants in the file. I think it's very important that if someone is going to complain about a facility, that their anonymity be protected if they want it to be.

These findings, and there's more findings of this nature in the report, they amply demonstrate that the public files are not being kept as they should be by law. These public files are the primary access that facilities have on how a facility is to be operated and the type of services it's supposed to provide children. I think it's important that these files be kept the way they're supposed to be.

The findings also suggest that a lot of information is not collected as it should be. The evidence points to uneven collection of information and lack of the annual inspection visits which are a vital part of the monitoring of these facilities.

A number of recommendations flow naturally from these findings. There needs to be a clear policy of public information and confidential information for group home facilities. These policies need to be made accessible to parents and other advocates so that they can know they have a right to independently look into the operation of a facility. There needs to be a clear written procedure for the maintenance of public files. I think the most important outcome of this study for this committee to consider is the necessity for public access to how licensing fulfills its function and how group homes operate. This ties in real clearly with what Peter Bull was saying earlier. There is never going to be a guarantee that the system can protect all children that are in out-of-home care, and we need to open up avenues for scrutiny of how the system is operated and encourage interested community advocates, parents, guardians, whoever, to take a closer look at the types of services that people they care about are getting.

Another way to look at this is just as consumer protection. Children, as consumers, rarely have the ability to say anything about the service they receive. It's important that parents and interested others have a right to receive information about the facilities they're going to be placing their children in. They have a right to know if there have been any regulatory violations and to judge for themselves whether they consider them serious or not.

They also have a right to find out, as we did, whether licensing is fulfilling its legal mandate and actually regulating its facilities.

Thank you.

[Material submitted by Ms. Roach appears in the appendix.]

Senator CRANSTON. Thank you very much.

Ms. BAXTER. My name is Kathy Baxter and I am project director for the institutional abuse project.

We were funded last January by the State office of child abuse prevention. The San Francisco Child Abuse Council had been in existence for 5 years, and I really have to admit that for 5 years we spent most of our time dealing with natural parents who abused their children, we had very little to do with children in out-of-home care.

We wrote a proposal to the State office of child abuse prevention and said, we're interested in the whole area of institutional child abuse, and to our surprise, we were funded last January to be a 1-year pilot project program. Once we were funded, we said to ourselves, what are we going to try to do. We have 1 year. What we were told by most people was are you going to end that year with just a group of papers that you compiled saying that cerain things needed to be done and really not do anything concrete to change the system.

We decided that what we would try to do was, No. 1, increase public awareness that children can be abused and are being abused in out-of-home care. Second, we would try to do something that we though would be helpful in the whole area. We took the two national training curriculums that had been developed for child abuse and neglect, which really did not mention anywhere abuse in out-of-home care, and we spent the first part of the project writing a new training curriculum. We completed that and did outreach to all of the group homes and 24-hour children facilities in a six-county bay area target population (San Francisco, San Mateo, Santa Clara, Alameda, Contra Costra, Marin).

We also approached foster parents in the bay area and said, we have a training package that we would like to offer to you. And so far this year, we have conducted 50 training sessions. What we have found basically is that there is extremely little training being done for group home staff people and also foster parents. Most of the counties have done very little in the way of training.

Our curriculum really had a twofold purpose. First, we felt that a number of group homes were receiving abused and neglected children and we found that the staff had very little in the way of ongoing training how to work with these children. We also found foster parents who were saying to us, we're getting more and more abused children into our homes and we don't know how to deal with them.

We have been doing training over this past year. Our training consists of identification of child abuse and neglect, the dynamics of child abuse and neglect, sexual abuse, child neglect, and alternative methods of discipline. We've made this available to different group home staff, and foster parents. Also another curriculum component developed deals with the reporting law in California. What we had been finding out is that very few facilities are aware of the California reporting law on child abuse and neglect (Penal Code 11161.5).

We will go into facilities and ask directors, have you had any incidents of child abuse or neglect in the past year. At first usually people will say no and then after you've been there for awhile, you get, oh, yes, we had an isolated incident. "Did you report that?" "I didn't know I had to report it." Staff members think that they're not mandated to make reports.

At the end of our 1-year pilot project, statistically on paper, I can tell you we had approximately 20 cases of child abuse and neglect in out-of-home care in the six bay area counties. To us that's an improvement. It's a beginning because 1 year ago when we started the pilot project, we had no statistics available.

We have a child abuse reporting law, but is is very, very confusing in out-of-home care. Licensing gets a complaint of child abuse and neglect and licensing staff may deal with it. If placement staffs get a report, they deal with it. Whoever else gets a report, they deal with it. There is no central reporting agency.

One of our strongest recommendations is there has to be an independent agency to handle these reports. I do not feel comfortable with a placement worker who has placed a child in a facility receiving a report of child abuse and neglect and doing an investigation themselves. I do feel we have to have an independent agency to do this kind of work. I support what has been said, ongoing independent monitoring is extremely important. We found this again with foster parents. If an alleged incident of foster care abuse is reported, it's very difficult to track that down to find out what department got the complaint, and then, what happened to it. We do not have a system, in other words, in California right now to handle these complaints. So it is no wonder that we do not have any statistics to give you that are very representative of the problem.

We have spent a good deal of our time also working with groups that already exist and that are doing something, we think, about the problem. We have one part in our training curriculum called program components and we are offering this to the owners of facilities, to placement staff and licensing staffs to say to them, when you go into a facility to do a review, what you you look for? Do you know what to look for? What we have been finding is a lot of these people do not know what to look for when they go into a facility. We have taken materials that have been developed by the California Association of Children's Residential Centers, what they call their peer review system. This is a group in California of group home people that go in and do reviews of each other. A lot of people have put this system down and said that, peer review really isn't very valid. We think it's a beginning step. What better group should look out for their reputation and the quality of service children are getting than the people that have the children. We have taken their peer review system and are using that in our program component curriculum.

We also are working with a group called Bay Area Action for Foster Children. This group is very, very committed to having a citizen review model be implemented in California. We feel very, very strongly in the project, that there has to be involvement from all of us citizens or very, very little is going to change. Citizen review is another beginning step.

When we started out this project, we had a very limited definition of child abuse in institutions. We looked at it simply as any physical act, sexual abuse or any kind of emotional abuse we came up against. We have broadened that definition to include the lack of monitoring in California of children. The Children's Defense Fund did a study and California is one of four States proven to very poor in the monitoring of children in out-of-home care.

Also we're concerned with multiple placements of children. Most of the testimony that you've heard previously we support: We really have grown in our definition of abuse. It is just as abusive to have a child go through 15 placements or as Jolly K. talked about, 33 placements, as it is to physically strike out at that child. Our definition has expanded. We have found ourselves working in a system that we knew very, very little about and over this past year have tried to gain some information and I think we're at a very beginning step. Someone earlier said that we are at the tip of the iceberg.

One year ago today when we were funded as an institutional abuse project, we were told by many people in the six counties that it was a waste of money, that this money should be going to fight abuse between natural parents and their children. It is very, very heartening to think that 1 year later, we are all sitting here before you at what we are calling institutional abuse hearings. To us that is a big, step, in public awareness. We have come to a point where people are no longer saying it doesn't exist.

What concerns me is what do we about it? We feel that what we are doing is just one step, training. Training staff, for the most part, that are inadequate and not trained to deal with the difficult children they have before them, and the foster parents that receive very little training. We have to ask ourselves, I think, at the end of this project. A very difficult question: We say that numbers of abused and neglected children are being removed from their families because their natural families were abusive. We remove these children and we think that we've saved them. We might have saved them from an abusive situation at home. What we're now having to look at is that maybe where we're sending these children is not better or maybe even worse than the natural family we removed them from in the beginning. I heard Dr. C. Henry Kempe, from Denver, most recently at a conference say that if we cannot assure a child that where we are sending them is going to be better than the natural family that we're taking them away from, we shouldn't do it in the first place. I think this is a very sobering thought we are going to have to face now.

Thank you.

[The prepared statement of Ms. Baxter follows:]

UNITED STATES SENATE - - - COMMITTEE ON HUMAN RESOURCES
SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT

ABUSE OF CHILDREN IN INSTITUTIONS
January 4, 1979
San Francisco

San Francisco Child Abuse Council

The San Francisco Child Abuse Council is a non-profit private organization which was established in November 1973 as a coordinating and educational body. A four-year grant was awarded from a private foundation (Rosenberg).

The San Francisco Child Abuse Council has a 23-member policy-setting Board, which maintains fiscal responsibility for the Council. The Board of Directors has nine appointees representing the major public agencies in San Francisco. They are: Juvenile Court, Youth Guidance Center; Department of Social Services; San Francisco General Hospital; Public Defender's Office; San Francisco Police Department; Community Mental Health Services; Deputy District Attorney's Office; San Francisco Unified School District; and the Department of Health. In addition, there are 13 at-large members elected by the Membership. The at-large membership consists of individuals interested in children's and family services. There are currently approximately 800 Council members.

In October 1977, the Council submitted a joint application with the San Francisco Department of Social Services to receive California Department of Health money (SB354 Dymally)* to establish an innovative pilot project in the prevention of abuse and neglect of children in out-of-home care. The joint application was accepted, and a $95,000 grant was awarded to conduct a one-year demonstration project in the 6-county Bay Area specified in funding legislation (San Francisco, Marin, Contra Costa, Alameda, San Mateo, Santa Clara).

The focus of this preventive program has been the training of personnel involved in the management of 24-hour children's facilities and foster parents. The training was specifically designed to optimize the quality of care children receive as well as provide educational materials in the identification, case management and treatment of child abuse and neglect.

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* Senate Bill 354 (Dymally) was introduced to the California Legislature in 1974. It passed pending funding from the Federal government which was delayed until July, 1977. At that point the components of this legislation took form and the Office of Child Abuse Prevention began operation. This 1974 legislation, which was three years late in getting off the ground, singles out California as a forerunner. At the core of the bill is the Office of Child Abuse Prevention which administers all federal money under Public Law 93-247 and coordinates all state-wide child abuse activities.

In order to identify incidents of abuse, it is first imperative to provide facility workers and foster parents with knowledge of physical and behavioral indicators of child abuse and neglect. Unless the problem is first acknowledged, little progress will be made in recognizing even obvious signs. Pursuant to carrying out the demonstration project, a great deal of research was undertaken, which has enabled Project staff to become conversant with salient issues in the problem of maltreatment of children in out-of-home care.

The specialized curriculum prepared for training by the Pilot Project has stressed the importance of the relationship between familial and non-familial child abuse. It also offers workers and foster parents the practical knowledge which they can apply in their day-to-day work. It is not easy to supervise children in out-of-home care. The fact that children are not in their natural environments will create varying degrees of hostility and maladjustment. Workers and foster parents need to be skilled in handling children placed in their care. They need tools to achieve desired goals. Workers and foster parents also require support and encouragement. Many cases of over-disciplining could be avoided by providing workers and foster parents with alternative methods to corporal punishment, and providing a mechanism to decrease worker stress.

The California Out-of-Home Care System

In California as of January 1978, 26,923 children are in out-of-home care. 77% of these children are in foster family homes (at a cost of $2,929 per child); 23% in group homes and institutions (at a cost of $12,756 per child). In California 80% of children are supervised by the Departments of Social Services; 8% are supervised by Probation Departments; 7% by private adoption agencies and 5% through other private agencies. Annual cost for dependent children in out-of-home care is $141 million per year.

In San Francisco, there are a total of 1,393 children in out-of-home care. 970 children are in family foster homes and 423 children are in institutions. (1)

Statement of the Problem

The problem of Child Abuse and Neglect (CA/N) in the child care institutions of society has been frequently identified but never methodically studied. The issues were highlighted by David Gil, D.S.W., during the 1973 hearings of the Senate Subcommittee on Children and Youth, when he stated that "reported incidents involve nearly exclusively abuse of children in their own home. There are hardly ever any reports of child abuse in schools and children's institutions although this kind of abuse is known to occur frequently all over the country. Public authorities seem simply reluctant to keep records of child abuse in the public domain." The hearings failed to suggest any Federal solutions. (2)

The literature notes several references of CA/N as a problem in institutions or foster homes (3),(4),(5),(6),(7),(8),(9). However, aside from occasional newspaper articles, a few reports by concerned citizens, journalistic reports, and a chapter in a book on child abuse, there is little factual information about institutional CA/N. T.M. Jim Parham, Special Assistant to President Carter commented, "...to his knowledge, institutional Child Abuse has received no attention as yet." (10) The National Center on Child Abuse and Neglect (NCCAN) sponsored the first institutional Conference in June 1977, and strongly suggested that "institutions be monitored by an independent agency with power to investigate complaints and to conduct public hearings." (11) Few attempts have yet been undertaken to implement CA/N prevention programs in institutions.

The Legislative Budget Committee of the State of Washington documented, in a preliminary report dated 10/22/77, 37 cases of actual or potential abusive situations in foster homes and numerous cases of inappropriate group home treatment. The report is incomplete and the State Auditor stated that, "this is only the tip of the iceberg." (12)

Fred Krause, Executive Director of the President's Committee on Mental Retardation noted that 'The Federal Government does not keep any statistics that sketch a meaningful profile of the patient/inmate population under 18...even less is known about what goes on inside facilities caring for children because, for the most part, state-run institutions keep their doors shut to snoopers trying to learn how captive children are treated." (13)

CA/N in 24-hour facilities include individual instances of physical abuse or neglect of children; and situational occurrences, where the facility policy is abusive by practice, (e.g. extreme disciplinary techniques) or neglectful by disregarding children's basic rights (e.g. lack of medical attention when needed, lack of privacy, lack of sound nutritional care).

Operational Definitions

Institutional Abuse: The term "institutional abuse" has become a catch-all phrase for a wide variety of behavior. Initially, the Project's definition of institutional abuse was: 1) specific incidents of child abuse and neglect of children by caretakers; and 2) situational abuse where program policy and program operation result in mistreatment of children. In the course of the Project's existance, the term institutional abuse has expanded to include more subtle and pervasive practices throughout the system which undermine children's basic rights. The term "institution" refers to any 24-hour children's facility used by the Department of Social Services and/or Probation Departments as an out-of-home care placement alternative.

Abuse: Non-accidental physical injury or injuries to a child by a caretaker and/or a pattern of verbal assaults or coercive measures against a child which is destructive to a child's sense of self-worth.

Neglect: Failure to provide for a child adequate care and protection in the areas of food, clothing, shelter, schooling and medical attention and/or failure to provide the nurturance or stimulation necessary for developing the child's social, intellectual, and emotional capacities.

Sexual Misuse: Any sexual contact, ranging from exposure, fondling, oral sex to sexual intercourse, incest and rape between an adult and a child 16 and under. Children can also engage in sexual activity among themselves beyond the "normal" expression of sexuality during childhood, pre-adolescence and adolescence. These situations are also vulnerable to exploitation and should be looked at individually.

Out-of-Home Care: Residential institutions such as treatment centers, long-term shelters, detention homes, centers for the mentally retarded and developmentally disabled, group homes, foster homes, and Juvenile shelters.

Identified Contributory Factors of Abuse/Neglect in Out-of-Home Care

The San Francisco Child Abuse Council Institutional Abuse Project has identified the following areas which can contribute to the occurrence of abuse/neglect in out-of-home care.

1) There is very little "accountability" except as contingent on financial matters; in most cases, the facility administration has full discretion to grant or refuse access to its grounds and buildings.

2) Access by citizen groups including advocates, researchers, or review groups, is not guaranteed by statute in most states; unless an agency reports a case of suspected CA/N, the incidents/or situations can go undetected and unchanged.

3) Placement agencies are unable to closely monitor the care of children in these facilities due to heavy caseloads. They frequently accept verbal reports from institutional staff regarding the children. The Children's Defense Fund's study entitled "Children Without Homes" (1977) stated that "California was one of 4 states most negligent in monitoring local compliance with State regulations."

4) Staff are frequently well-intentioned, but untrained; in-service training sessions are irregular.

5) Childcare Supervision is demanding; foster children can often be difficult.

6) Childcare workers are underpaid and overworked; worker support is minimal.

7) The reporting law in regards to CA/N is not understood, or acknowledged by administrators, and the procedures for reporting are not usually written or clear to the entire staff.

8) When CA/N is detected, the person inflicting the injury is usually automatically fired; little is done to explore the institution's responsibility in the matter.

9) Discipline and treatment techniques are sometimes designed by individual facilities without outside consultation.

10) Children who reside in facilities are infrequently asked to express their opinions about what changes are needed, how safe they are within the facility, and how they perceive the quality of care they are receiving within the facility.

Project Goals

Because of the above-mentioned contributory factors in CA/N in 24-hour children's facilities, it seems clear that the following areas need attention and can be regarded as preventive or remedial efforts.

I. To Increase Public Awareness of the Problem of Abuse and Neglect of Children in 24-Hour Children's Facilities.

Children's facilities were an outgrowth of the Juvenile Justice Reform system of the 18th and 19th centuries and were developed to take orphaned, deprived or wayward children off the street or remove abused, neglected children from their parents' jurisdiction.

Once removed, the concept was that children would be placed in facilities with trained and caring staff, who would provide the child with the love and guidance necessary to counter their previous experiences and help them develop normal, healthy lives.

This concept has often fallen short of its intended goal and the very facilities designed to protect vulnerable children has often violated and abused them.

It is very difficult and painful for the public to recognize that children's shelters are not always providing the care the taxpayers expect. Administrators of children's facilities feign ignorance when told about the recent concern over the issue of institutional abuse, but will likely recall the one or two "isolated" incidents which occurred in the past. Other administrators perceive a real danger in sudden accountability: some practices, accepted and unquestioned in the past, may suddenly become vulnerable and scrutinized. Anything that confuses people as much as the irony of abuse and neglect of children in the systems designed to provide safety, is difficult to acknowledge. But a more well-informed public might demand better monitoring of society's shelters.

II. To Improve the System for Reporting CA/N of Institutionalized Children

The institution is a "closed" social system. Its governance, administration and funding are not easily scrutinized by outsiders. Events that occur within the facilities are often withheld from public view. Children have developmental and emotional problems which restrict their credibility and they rely on the ethical and moral qualities of the facility and its staff. Parents are reluctant to report negative conditions for fear of having their child expelled, or being perceived as "cranks". The administration usually handles problems "in house"; CA/N reports under California Penal Code 11161.5 are rarely made (See attachments A & B). Licensing and placement workers receive filtered data about CA/N, and have a difficult time determining facts. Employees risk their jobs or suffer censure from their peers if they report CA/N under the requirements of 11161.5. CA/N reports are usually in the form of "complaints" made to a number of sources. The data, therefore, has not been effectively coordinated, analyzed or shared among placement agencies.

There are several reasons why incidents of abuse and neglect in out-of-home care are under-detected and under-reported. But the self-incriminatory aspect of reporting suspected occurrences of child abuse within facilities is the single greatest deterrent of reporting; administrators are simply unwilling to obtain a "bad" reputation and stand to suffer a financial deficit, by virtue of losing referrals (license). This is a real concern, and to avoid it would be futile. This problem must be kept in mind when dealing with residential facility owners and administrators, who must be persuaded that the child's protection and safety is the first priority, as well as the correction of precipitating factors.

III. To Provide Remedial Action of Suspected Child Abuse and Neglect in 24-Hour Children's Facilities

One of the identified problems in the area of institutional abuse is the lack of education and training of identification, reporting, and handling of suspected incidents of CA/N. Greater awareness of the problem's existence through education will result in more frequent identification of the problem.

Clearer knowledge about reporting will encourage adherance to the law. The proper handling of cases will lead to more introspection by institutional staff of how to prevent further occurrences.

In CA/N, prevention has remained a nebulous area. Education and training which results in more appropriate acknowledgement and response to abuse and neglect is the single most effective tool to date.

The National Center on Child Abuse and Neglect Standards for childcare institutions state that in order to achieve high-quality care, staff should be provided with "regular pre-service and in-service training including supervisory positions, and training by professional staff for childcare personnel who are in day-to-day contact with the children." It further specifies that training should focus on:

- "how to handle problem children in ways which do not involve physical discipline..."
- "recognition of child abuse and neglect..."
- "internal and external child abuse and neglect reporting and assessment procedures..."

The San Francisco Child Abuse Council Pilot Project on Institutional Abuse has developed a specialized training curriculum to be used with personnel involved in the care of children in 24-hour facilities and foster homes. The curriculum is also designed to provide valuable information for placement and licensing workers by enabling them to detect vulnerable programs within high-risk institutions. This enhances decision-making by increasing their ability to assess the probability of CA/N within an institution. A curriculum unit entitled "Self Evaluation of Program Components" lists circumstances that might help predict a high-risk facility.

IV. To Develop a System for Investigation and Corrective Action of CA/N Incidents in Children's Facilities

There has been a great hesitancy about reporting suspected incidents of CA/N in 24-hour facilities which has adversely affected the creation of a system for investigation of allegations as well as corrective action alternatives once CA/N is detected.

Clear procedures for responding to allegations of abuse and neglect need to be established and guidelines for conducting such investigations need to be prepared. Once the investigation is conducted, obtainment of consultation when appropriate and case planning strategies need to be ensured.

All cases of CA/N are different. The degree of worker pathology/stress needs to be explored in allegations of CA/N. In allegations of situational abuse or neglect, identified experts in the questioned area will be provided to determine a remedial program.

Corrective action techniques will be undertaken after a thorough evaluation of the specific person and action in question has been performed. Personnel action may be appropriate in some cases, but not the only option. Policy and program changes may be necessary in cases of situational abuse or neglect, and budgetary recommendations may reflect underlying contributory factors which are deemed serious.

The area of institutional abuse of children is due the intense attention that we have given familial child abuse in the last decade. Recognition of this problem is a beginning step. Only after recognition of the problem can appropriate interventive and preventive plans be implemented so vulnerable and lost children will be given the opportunity to develop into healthy individuals.

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Senator **Cranston**. Thank you very, very much.

Mr. **Pechter**. Senator, my name is Steve Pechter and I'm with the Children's Advocacy Center in Oakland. We're a private, community-based, nonprofit organization. Our work is primarily with the public schools. We assist students to defend their rights. We assist parents to be more effectively involved in educational decisionmaking. We work closely with families by providing lay representation in such areas as appropriate special education placements, the rights of pregnant minors, and also bilingual education. All of these are very often lead-ins to institutional care at some point.

Too often those of us who provide services to children, even with the best intentions, lose sight of the needs of those children. Those needs are what we need to be talking about. Under the cloak of crusading for kids, we start advocating vehemently for changes which are instead motivated by what is best for the institutions themselves.

Institutional responses become very suspect when we get so caught up in cost effectiveness and maximizing existing resources while actually protecting our own turf that we no longer hear the voices of those children who are supposed to be reaping the benefits of all our efforts.

I'd like to raise two main issues. First would be what voice do children have as we address what their needs are?

Second, how do other kinds of institutional care for children reflect and affect upon children in residential care. I'd like to eventually lead to the conclusion that the children very quickly develop a sense of powerlessness, a sense of alienation from all sorts of experiences. They consequently learn to respond irresponsibly because of this sense of alienation and even defiantly. Yet at the same time, the way the framework is set up, fosters a further dependence on these institutions.

Children in out-of-home care are especially vulnerable because they have no independent advocates who can act on their behalf.

I would like to raise one issue in the schools that impacts directly on residential care. In our work with special educational needs of children, we see many instances where children are difficult to handle, whose behavior is indeed disruptive but who, nevertheless, are improperly shuttled off into classes for mentally retarded. These children do need attention. However, the actions of personnel without sufficient training and experience, and limited options for providing special help start children, especially black male children from low-income families, on a track from which they rarely escape. Entry into the juvenile system often follows from this track. The Federal law attempts to remedy this situation by providing for appropriate educational placements.

One remedy is meant to be through mainstreaming. To be successful, it requires dedicated efforts to sensitize both staff and normal children to the needs of special children and supportive help to integrate children back into normal environments. However, prevailing attitudes in the schools, and I'd like to suggest also in residential care, run counter to the thrust of mainstreaming.

The rationale is as follows. Pressures to serve children now are indeed great as funding levels have declined. And available resources go primarily to bolstering existing special placements. The support services necessary to work for transition back to normal environments have been slighted. In the schools, regular classroom teachers, aware that mainstreaming right now means dumping these kids back, see this as a disturbance and rightly so.

So everyone concludes these children are better off with peers like themselves, able to learn in a supportive atmosphere where they don't run into the hostility of other so-called normal children. Identical situations face children in out-of-home care and the same rationales are invoked for entrenchment of existing practices. For developmentally disabled children in the State hospitals, it is said that they're being provided with an environment where they receive the support of others like themselves, where they'll not be isolated and made to feel worthless. And, indeed, some children could not function as capably elsewhere. Yet those that could often find similar obstacles, insufficient resources and few personnel with skills necessary to provide that transition. Children in foster care feel the same isolation through breaking of the ties with natural parents. These children, who may also be in the best possible placement at the time, often still have strong attachments to their former homes and their need to work through many changes with contact with the natural parents and with their help must be identified, understood, and met.

In Alameda County the lack of suitable group homes for children with emotional difficulties, and extremely scarce foster care for handicapped children means sending them such a distance from their natural parents that continuing contact is virtually impossible.

I'd like to finally address some recommendations, many of which have been stated before, as to how to to tackle the abuses which do exist. Some suggest greater regulation through more stringent monitoring. Yet many of the county administrators I've talked to say that they feel that they are stymied by the welter of regulations. Without any incentive to provide reports of abuse, it's no surprise that the numbers actually reported are very low. Despite legal mandates, it seems doubtful that strict monitoring alone would reveal anything but the most flagrant violations.

To draw another parallel with the schools, the State Department of Education, upon receiving numerous individual complaints of noncompliance with the special education laws, acknowledged that, one, they had not set up any formal office to process these complaints and, two, that the monitoring mandated by the law would not result in any sanctions, simply technical assistance.

In such cases where the State formalities are unreliable devices for monitoring, the Advocacy Center's response has been to rely on parents more strongly then ever to voice their complaints. However, children in out-of-home care have no such advocates who can act on their behalf without compromise. Even though all who work with children consider themselves staunch advocates, as long as they're forced to indict themselves or their coworkers in order to really protect the child's interest, they're still bound by political and administrative straightjackets.

I'd like to make two final suggestions. First, instituting more uniform procedures for handling children, including the complete dissemination of regulations and rigorous training for all workers will allow everyone to appreciate without feeling threatened what kind of care is indeed appropriate. And of equal importance, the children themselves would have a better understanding of what responses they can expect and what behavior is acceptable. I think it would increase their sense of institutions responding to their needs and encourage more responsible behavior.

Finally, perhaps the missing link, is to ask children how they feel about the care they receive. If we're truly trying to meet the needs of children, either in the home, in the community, or in some form of institutional care, we must be prepared to allow children ample opportunity to tell us what their needs are and not merely ask them to respond to definitions imposed by us, no matter how capricious and arbitrary as in some cases or even well reasoned and conscientiously applied as in others.

Thank you.

[The prepared statement of Mr. Pechter follows:]

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The Children's Advocacy Center is a private, community based, non-profit organization involved primarily with the public schools. CAC helps parents to guide their children's learning more effectively. We provide simplified information to families concerning student's rights, and parent's rights to participate in educational decision-making. We also work closely with families by providing lay representation in such areas as appropriate special education placements, suspension and expulsion hearings, the rights of pregnant minors, and bilingual education.

Our work brings us into contact with children whose lives are significantly affected by institutions. Since our direct knowledge of out-of-home care is limited, CAC would like to address several tangential problems that may shed some light on the immediate concerns of the committee here today.

Too often those of us who provide services to children, even with the best intentions, lose sight of the needs of children- and those needs are what we need to be talking about today. Under the cloak of crusading "for the kids," we start advocating vehemently for changes which are instead motivated by what is best for the institutions themselves. Institutional responsiveness becomes very suspect when we get so caught up in "cost-effectiveness," and "maximizing existing resources" while actually protecting our own turf, that we no longer hear the voices of those children who are supposedly reaping the benefits of all of our concerted efforts.

In the schools, as in residential care of any kind, discipline is a large part of the guidance we provide, and we must constantly distinguish between arbitrary rules and inflexible, uncaring attitudes which harm children, and those which are necessary and beneficial.

In our work with special educational needs of children, we see many instances where children who are difficult to handle, whose acting out behavior is indeed disruptive, are improperly shunted off into classes for the mentally retarded.

These children do need attention; however, the actions of personnel without sufficient training and experience, and limited options for providing special help, start children, especially black males from low income families, on a track from which they rarely escape. Entry into the juvenile system often follows from this tracking, and institutional detention makes children feel even more like outcasts.

In an attempt to provide appropriate settings for all children, PL 94-142, the Education to All Handicapped Children Act, calls for placing children in as normal an environment as possible- more popularly known as mainstreaming. Mainstreaming is designed to offer greater flexibility to respond to children whose needs can not be fit easily into the molds that have been created. To be successful, it requires dedicated efforts to sensitive normal children to the needs of special children and supportive help such as in-service training of teachers.

However, prevailing attitudes in the schools and in out-of-home care run counter to the thrust of mainstreaming and foster increased dependence on segregated placements and the isolation of institutions.

The rationale is as follows. Pressures to serve children with special needs are great, and available resources have been absorbed by existing special classes. The support services for regular classes have been slighted. Regular classroom teachers, aware that mainstreaming right now means having these "unwanted". children dumped back into their laps, see this as a disservice to themselves and to the kids. So, everyone concludes, these children are better off with peers like themselves, able to develop in a supportive atmosphere free from the hostility that their presence in normal classes would provoke.

An identical situation plagues children in out-of-home care. And the same rationales for entrenchment of existing practises are used. For develppmentally delayed children in state hospitals, it is said that they are being provided with an environment where they receive the support of others like themselves, where they will not be isolated and made to feel worthless. Indeed, some children could not function as capably elsewhere. Yet those who could, often find similar obstacles: insufficient resources and few personnel with the skills necessary to work toward that transition.

Children in foster care feel the same isolation when the importance of ties to their natural parents are ignored. These children, who may be in the best possible situation, often still have strong attachments to their former homes, and their need to work through many changes with the help of their natural parents must be identified, understood, and met. In Alameda County, the lack of suitable group homes for children with emotional difficulties, and extremely scarce foster care for handicapped children mean sending them such a distance from their natural parents that continuing contact is virtually impossible.

Another aspect of institutional neglect can be seen in the circumstances surrounding the highly publicized infant mortality problem in East Oakland. The conditions are extremely serious, considered not only from the high rate of infant deaths, but also from the related issues of much higher incidences of birth defects and disabilities that can be traced to poor pre- and post-natal care. Traumas in the early months haunt these children throughout their lives.

All conscientious local legislators and health care administrators have embraced this issue since the media splash last spring brought to the forefront a problem that everyone has been aware of for some time. At stake are health services to low income, minority women. It is either non-existent or inadequate. But the needs of these young mothers, for a high percentage of them are teenagers, and their children, are crunched between the pincers of political and administrative in-fighting and posturing, impassable funding mazes, and providers who are sometimes insensitive to the needs of the people they serve.

Finally, now that we have attempted to enlarge the scope of the problem, what can be done to improve the experiences of children in out-of-home care?

Abuses, whether due to incompetent individuals or inhumane working conditions, must be erased. Some suggest greater regulation through more stringent licensing and monitoring. Yet many county administrators I have spoken with say that they are stymied by "welter of regulations."

Without any incentive for providers to report incidences of abuse, it is no surprise that the numbers actually documented are extremely low. Despite legal mandates, it seems doubtful that stricter monitoring alone would uncover any but the most flagrant violations. To draw another parallel with the schools, the State Department of Education, upon receiving numerous complaints concerning non-compliance with the special education laws, acknowledged that 1) they had not set up any formal office to process these individual complaints, and 2) the monitoring mandated by the law would not result in any sanctions. Rather, they would offer technical assistance to school districts to encourage them to move into compliance with the law.

In these cases where the state formalities are unreliable devices for monitoring abuses, CAC's response has been to rely on parents more strongly than ever to voice their experiences and their complaints. However, children in out-of-home care have no advocates who can defend their needs without compromise. Even though all who work with children consider themselves staunch child advocates, as long as they are forced to indict themselves or their co-workers in order to really protect the child's interest, they are still bound by political and administrative straightjackets.

CAC would like to make two final recommendations. First, instituting more uniform procedures for handling children, including complete dissemination of regulations and rigorous training for all workers, would assist everyone to appreciate without feeling threatened what kind of care is indeed appropriate for children in these placements. And of equal importance, the children themselves would have a better understanding of what responses they can expect and what behavior is acceptable.

Perhaps the missing link is to ask children how they feel about the care they receive. If we are truly trying to meet the needs of children, whether in the home, in the community, or in some form of institutional care, we must be prepared to allow children ample opportunity to tell us what their needs are, and not merely ask them to respond to definitions imposed by us - no matter how capricious and arbritrary, as in some cases, or even well reasoned and conscientiously applied, as in others.

Senator **Cranston**. Thank you.

Ms. **Apkaw**. My name is Patricia Apkaw. I'm with the Urban Indian Child Resource Center. To my right is Rosie Irwin who is also an employee of the same agency.

We are here representing the Urban Indian Child Resource Center of Oakland, Calif. For the last 4 years we have provided services to Indian children and their families who have been victims of child abuse and child neglect. Our role has been to provide comprehensive services to Indian families, to develop Indian foster homes, and to supervise private and institutional placements of Indian children.

The term "institutional abuse" is not original with the center. Usually, institutional abuse refers to the beating of prisoners, doing psychosurgey on inmates in mental hospitals, and other such indications of physical abuse of people who are incarcerated. Some of the instances of institutional abuse practiced against Indians comes under this definition, but experience at the center indicates a broader definition is in order; namely, that major institutions in Anglo society, such as bureaucracies, churches, schools, and child care and family service institutions have set out to deliberatly alter or destroy major institutions in Indian society. What is going on, then, is not a case of abuse against an individual who happens to be a physical institution; rather, it is a case of social institutions in one culture abusing whole segments or classes of persons in our society.

When we testify against institutional abuse, we are challenging the total ignorance of our Native American cultural heritage and upbringing by institutions. Without understanding of our culture, institutional abuse is a daily reality for Indian people.

In the child abuse/neglect field, investigators have looked for causes in the life histories of abuseful and neglectful parents. The conclusion, which has become a virtual cliché, is that these parents were themselves abused or neglected by their parents.

It is extremely important to emphasize that for the Indian parents seen at CRC the abuse and neglect which they suffered as children came not from their parents, but from Anglo-oriented institutions. That is, the life histories of parents seen at the center shows an extremely high rate of early separation from natal families by foster placement and/or boarding school education. These parents were removed from their homes at an early age and placed in non-Indian settings. Many began life with "empathetic mothering" but their bonds with their families were destroyed through outside interference.

Institutionalization meant that Indian children were denied the opportunity to learn to be truly Indian. Even when they grew up on the reservation and lived at home, they nonetheless spent years in Anglo-run schools where they were told through textbooks and by teachers that their ancestors were savages who stood in the way of progress, that their religions were pagan superstitions, that their languages were inadequate for the modern world, that their homes were dirty, squalid, and unsanitary. As an Indian woman wrote, "It seemed as if it was a crying shame to be born as and labeled 'Indian.' We were made to feel less than human beings."

Today, this situation is only slightly modified. Most Anglo institutions make it impossible for a person to be both Indian and successful.

On the one hand, the child is told to give up being Indian and become like Anglos, and on the other hand the child can see that Anglo society discriminates against Indians. The child is faced with a choice that few adults are capable of making—to remain Indian is to face a future that looks bleak and doomed to economic failure, but to turn one's back on one's heritage is to turn against one's parents and one's identity. Institutionalization of Indian children tends to bring them into increased conflict with themselves and their families, and to further destroy family and community support systems.

We watch this same cycle repeated with our children today. Ignorance of and lack of respect for Indian culture cripples the ability of child welfare agencies and non-Indian personnel to adequately care for Indian children and Indian families.

Lack of knowledge of Indian child-rearing practices contributes to misleading evaluations of parental relationships and interactions among family members. Evidence of parental affection and commitment to children is disregarded when mothers do not display physical affection for their children in the presence of strangers and when a passive style of interaction is interpreted as disinterest.

The inability of non-Indian agencies to help the child develop in a manner compatible with his family and his community undermines his self-image. The child begins to have self-doubt and self-hate. He becomes restless and frustrated, as he cannot begin to tell you his side of the story. He begins to withhold thoughts or feelings. Additional adaptations to Anglo culture weaken the child's ties with home and tribe.

Lack of cultural knowledge further cripples the ability of agencies to work with the child's family to strengthen the family unit or to involve the family in planning for the child's future. Our past experience in working with children in institutions has indicated inappropriate case planning by not involving the parents based on inappropriate structure and time expectations. This often places the agency in conflict with the family rather than providing support.

Lack of cultural awareness severely limits the ability of agencies to use resources within the Indian community and within the family. Often children are placed by the county with strangers rather than utilizing the traditional helping networks of extended family and extended family friends or recognizing resources available within the Indian community. Indian children are removed from the community even though it is customary for Indian families to shelter children or families in need. Due to institutional injustices these children are not given the option to be placed within the Indian community.

The magnitude of institutional abuse towards Indian people is clearly seen through the results of recent surveys and studies which conclude that twice as many Indian children as opposed to non-Indian children are placed in foster homes.

Our program was initially a demonstration project—a project to develop a culturally relevant approach to dealing with child abuse and neglect. Because we felt that our experiences needed to be shared with other people, we now have an evaluation of the model and are submitting it as part of our testimony to the committee.

We encourage the subcommittee to advocate for the inclusion of cultural concerns that affect programs for children and also to support more social services programs that are operated by "grassroots" minority groups. It is through these new innovative, culturally sensitive programs that we can begin to really meet the needs of all children. Thank you.

Senator **Cranston**. Thank you very much.

Those are certainly troubling figures on the number of Indian children that are placed into foster care circumstances.

In your work with Indian families with child abuse and neglect problems, have you focused much of your effort on trying to help families avoid foster care?

Ms. **Irwin**. Right now we have a family support network. That's Indian parents that volunteer to take in children which, if they were not placed, would go to foster homes.

Senator **Cranston**. Thank you very much.

Ms. Baxter, I wanted to ask you about this. You submitted with your testimony copies of two letters from the State Department of Health to county welfare directors indicating that the provisions of the California Penal Code requiring reporting of child abuse are applicable to situations where the abused child is living in an institution and that the abuse should be reported to an agency not responsible for the facility. Are there any other efforts of the state to provide for reporting of child abuse in institutions?

Ms. **Baxter**. Well, I think the fact that we were funded as a project is one of the things they are trying to do. What has been frustrating with the reporting situation is that we let people make reports to various places. You can refer to the Welfare Department, to the Probation Department, to the police, to the Health Department, to various places, so that if a foster parent is allegedly abusing a child, the report does come to placement and placement is within the Department of Social Services. So technically the report is handled, is being made correctly, but then it remains within the Welfare Department. In that statute, it does not say where you should report it elsewhere. Should you report it then to the police or to probation or to the Health Department?

What we are hoping is that there would be some sort of coordinating system. So we have asked that all reports be made to Child Protective Services in the six-Bay Area counties. But all that means is if placement receives a report, they will continue to handle the investigation, most likely, themselves but will give the report to Child Protective Services so we can even get a statistic because it is so broad, reports are being made all over. I would like to see an independent agency do that review.

I am told that in Connecticut, if a foster parent is accused of abuse or if a group home or wherever is accused of abusing a child, they turn it over to an independent agency that then goes in and does the investigation. They work closely with licensing and with placement but an independent agency does the investigation.

One of the things that was concerning to me was that when the National Center is funding four pilot projects now on institutional abuse, in order to even submit an application you had to be an agency that receives reports in order to apply. That totally eliminated projects such as ourselves from being an independent agency and applying. In order to do that, you had to do it with another agency. I would hope that these four pilot projects that are being funded by the National Center will at least try to build in an independent advocacy kind of program because it's very difficult for me to believe that the Department of Social Services, who are already supposed to be protecting these children, are going to be able to add anything new into the field.

Senator CRANSTON. Thank you.

Ms. Roach, I have one question I want to ask you. What reaction have you received from the State to your report and the recommendations?

Ms.. ROACH. The report went to the State in the end of October. We did receive one reply right before Christmas from the head of the new licensing division in the Department of Social Services. We had asked for a direct response to all of our recommendations, and basically the letter was an acknowledgement and a thanks. We're still in the process of following up on that.

Senator CRANSTON. I see.

I have some additional questions, including for you, Mr. Pechter, but because of time constraints, I'm going to have to have to submit them in writing to you and ask for written responses back.

I'd like to thank you, each of you, for your very helpful testimony, and I want to thank all of those who participated and those of you who have patricipated by your presence, even though you have not spoken. I'm glad that you were here and you were interested, and I want all of us to consider ourselves partners in an effort to deal with this problem together. Any help and guidance you can give us and any ways you can make our work more effective to expose the facts, find the solutions, and apply them will be very important to us.

Thank you very much. We'll have other hearings and get on with our work. Thank you very, very much.

We now stand adjourned.

[Whereupon, at 1:10 p.m., the hearing was closed.]

ABUSE AND NEGLECT OF CHILDREN IN INSTITUTIONS, 1979

WEDNESDAY, JANUARY 24, 1979

U.S. SENATE,
SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT
OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:35 a.m. in room 4232, Dirksen Senate Office Building, Senator Alan Cranston (chairman of the subcommittee), presiding.

Present: Senators Cranston, Riegle, and Hatch.

Senator CRANSTON. The hearing will please come to order.

OPENING STATEMENT OF SENATOR CRANSTON

Today is the second day of hearings of the Subcommittee on Child and Human Development looking into the problems of abuse and neglect of children residing in institutions or group settings.

Witnesses at the first day of the subcommittee's hearings—held on January 4, in San Francisco—presented very troubling testimony about the scope and dimensions of this problem and the shocking conditions in some institutions housing children. Many of the stories that witnesses told the subcommittee sounded like Charles Dickens' novels about the horrors of street urchins in 19th century London slums. For example, one witness testified that in an institution where her son resided, the children were tied to chairs or their beds for lengthy periods of time, sitting in their own waste for hours. This same witness described finding her son with an inch and a half laceration on his scalp, the edges of which were bloody and congealing. A month later, the wound, still untreated, had become a mass the size of a goose egg and his body was covered with bruises across his back and shoulders. We heard testimony of electric cattle prods being used as treatment on institutionalized children.

Other abuses reported to the subcommittee included pinching, slapping, jabbing pencils between the children's fingers, cold showers, confinement to cubicles or closets, withholding of food as punishment, forcefeeding, and pinching of genitals. One child was described as having had an institution worker place a trash can over his head and being forced by the worker to remain in a corner for a week. A parent testified about finding her child tied to a chair in the middle of the play yard. Another witness described a facility in which tear gas canisters were thrown into a room in which children were placed in solitary confinement.

We cannot tolerate conditions like these. We cannot tolerate abuse of American children or children anywhere, of course, like this, and we are determined to investigate until we know exactly what is occurring and determine what steps to take to bring this sorry situation to a halt.

Despite repeated stories of brutality and abuse, there does not appear to have been any systematic examination of the scope of this problem on a national basis, nor any efforts to deal comprehensively with the problem. The purpose of these hearings is to gather specific information on the scope of the problem, and it appears to me at this point to be a very serious problem, and to develop alternatives for dealing with this child abuse.

Many of these children are being supported in institutional care by Federal funds—either through title IV-A or title XX of the Social Security Act or other Federal programs. Our investigations show that millions of Federal dollars spent each year for institutional care of American children end up financing virtual hell holes where children are beaten, starved, and sexually abused. Although these hearings serve a useful purpose by focusing national attention upon the problem, that is not enough. The Federal Government has a responsibility here—both to be concerned about this abuse and to find prudent and effective ways to provide protection for these children—particularly those supported by Federal funds—against brutality and abuse.

I am particularly pleased today to have as witnesses, representatives from the Civil Rights Division of the Justice Department and from HEW's Office of Human Development Services. Both of these agencies are already involved to some degree in dealing with the problem of institutional abuse of children. I hope to learn from these agencies precisely what activities they are currently carrying out in this area, what additional steps they feel would be appropriate, and their plans to take such actions, and to coordinate their activities.

During the last Congress, I sponsored an extension of the Federal Child Abuse Prevention and Treatment Act. Under the provisions of this act, States which receive Federal funds for child abuse programs are required to establish a mechanism for the reporting and investigation of all child abuse and neglect—including abuse or neglect of children in institutions and out-of-home settings. Despite this requirement, it appears that very little has taken place to deal with institutional child abuse in the 42 States receiving funds under the act. Several months ago, HEW awarded four grants under the Child Abuse Act in the area of institutional child abuse, and this morning we will hear testimony from witnesses from the agencies receiving these grants as to what activities they will be undertaking.

On my own part, I intend to lead the effort during this Congress to enact the child welfare-foster care reform measure that I introduced on behalf of the administration as S. 1928 during the first session of the 95th Congress. We came very close to winning the final passage of this measure last year, but the enormous time constraints during the last few days of the 95th Congress prevented our achieving this goal. I plan to work with the administration, with Senator Moynihan, who worked closely with me on behalf of these provisions during the final days of the last Congress, and with Finance Committee Chairman, Senator Long, who was also supportive of our efforts to pass this measure, as well as with my two colleagues from California, Representative George Miller and Representative Jim Corman, who are also both deeply concerned about enactment of foster care reform legislation.

Additionally, I am an original cosponsor of S. 10, legislation introduced last week by Senator Birch Bayh, which would authorize the Attorney General to initiate or intervene in actions on behalf of certain institutionalized individuals, including children, whose constitutional or Federal statutory rights may be being violated. I will do my best to assist Senator Bayh in moving this measure forward during this Congress. Witnesses in California made specific reference to the importance of continuing the authority of the Attorney General, presently under attack in the courts, to engage in litigation to protect the rights of institutionalized children. They told the subcommittee that enactment of this legislation was a fundamental part of the steps needed to deal with the problem of institutional abuse of children.

So, we will be pressing forward on at least four points: first, pursuing oversight activities like this; second, actively seeking to enact adoption and foster care reform legislation; third, pushing for enactment of S. 10; and fourth, monitoring HEW's activities pursuant to the Child Abuse Prevention and Treatment Act and considering appropriate amendments to that act. I welcome whatever additional suggestions or strategies which our witnesses this morning and other concerned individuals and organizations may have to offer to our efforts to deal effectively with this problem of abuse of children in institutions and group settings.

Finally, at the first hearing of the subcommittee on the problem of abuse and neglect of children in institutional settings, I announced I was requesting the General Accounting Office to conduct an investigation of the reports that as many as 150 foster children were placed with the People's Temple prior to the mass suicide in Guyana. The GAO has begun its investigation and is currently checking the names on the lists of the dead from Jonestown against county foster care records in California. We expect to have some preliminary reports from this investigation in the next few weeks. But the apparent abuse of the foster care program by the People's Temple, although a dramatic example, should not obscure an even larger problem facing us in terms of abuse of children in institutions and residential facilities within the United States.

I want to stress that, of course, these abuses do not occur by any means in all institutions.

There are many institutions that have fine records of very appropriate, compassionate, concerned care for children in those institutions. We, of course, are focusing on those places where the situation is so sadly and shockingly the contrary.

Thus, this in sum is the focus of these hearings and the followup activities that we on the subcommittee will be pursuing.

We will now proceed with the Honorable Drew S. Days III, Assistant Attorney General, Civil Rights Division of the Department of Justice.

STATEMENT OF HON. DREW S. DAYS III, ASSISTANT ATTORNEY GENERAL, ACCOMPANIED BY JOHN E. HUERTA, DEPUTY ASSISTANT ATTORNEY GENERAL; LYNN WALKER, CHIEF OF SPECIAL LITIGATION SECTION; MARIE KLIMESZ, ATTORNEY, CIVIL RIGHTS DIVISION; AND KAREN SIEGEL, ATTORNEY, OFFICE OF LEGISLATIVE AFFAIRS, DEPARTMENT OF JUSTICE

Mr. DAYS. Thank you, Mr. Chairman.

I want to thank the subcommittee for the opportunity to appear today to testify about a subject which has been of great concern within the Department of Justice, the abuse of children in institutions.

With me today are John Huerta, who is sitting next to me, who is my principal deputy for policy and planning, and in the audience are also Lynn Walker, who is chief of our institutions litigation program, Marie Klimesz, who had primary responsibility for preparing my testimony, and Karen Siegel from the Justice Department's Office of Legislative Affairs.

As defined in the Child Abuse Prevention and Treatment Act, 42 U.S.C. 5101, child abuse and neglect means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person responsible for the child's welfare under circumstances which harm or threaten the child's health or welfare. When this legislation was enacted in 1974, the definition was intentionally written broadly enough to take into account the fact that, for many of our Nation's children, the person responsible for their welfare is employed by some kind of institution. As your invitation to testify noted, the Department of Justice has, since 1971, been involved as an intervenor or litigating amicus curiae in a number of cases concerning the constitutional rights of confined persons, and in several of those cases there has been substantial evidence of abuse of children, as defined in the legislation which is the subject of these hearings.

As the chairman also noted, legislation was under consideration during the prior Congress, and has been introduced in this Congress, to give the Attorney General explicit authority to institute suits against particular classes of institutions where he has reasonable grounds to believe that persons are being deprived of their constitutional rights. I am speaking of S. 10 and H.R. 10, which were introduced on January 15, 1979. When I testified before the Senate and House subcommittees having jurisdiction over the bills which were under consideration in the prior Congress, I stated that there were two reasons why such authorizing legislation was necessary. The first is that the experience of the Department in the litigation to which I referred earlier has demonstrated that basic constitutional and Federal statutory rights of persons confined in institutions are being violated on such a systematic and widespread basis to warrant the attention of the Federal Government. The second reason why an authorizing statute is needed stems from the fact that some courts have held that the Federal Government lacks the power to bring such suits absent authorization from Congress.

One court has even suggested that the United States lacks the requisite standing to intervene in an ongoing private suit. While the

United States is continuing to participate in litigation where the courts have allowed, the future is uncertain without passage of the bills I testified to earlier.

I have been asked to testify specifically today about the abuse of children in institutions with which the Department of Justice is familiar through its litigation, our perception of the extent of the problem, and any suggestions for effective methods of dealing with institutional abuse of children.

Beginning with our experience, the Department has participated in cases involving several kinds of institutions in which persons under 18 years of age are confined, including facilities for mentally ill and mentally retarded persons and juvenile detention facilities. In those cases, the following types of abuses against children have been found to have occurred.

In a case styled *Gary W. and United States* v. *Stewart*, C.A. No. 74-2412-C (E.D. La.), the Federal district court found that the State of Louisiana had placed delinquent and dependent children in private care facilities in the State of Texas where in some cases children were being abused and overdrugged and in which treatment was inadequate. When the medical experts employed by the United States in its capacity as plaintiff-intervenor visited a private child care facility in Houston, Tex., they found a 7-year-old severely mentally retarded boy in such a malnourished state that he was near death. We sought and obtained from the district court an emergency order requiring Louisiana State officers to remove the child from the facility and to transport him to a nearby medical center. I am happy to report that his life was saved. After trial of the case, the court entered an order detailing the following conditions found in the private facilities in Texas: Children tied, handcuffed, or chained together or to fixtures as a means of control and discipline; children being fed while lying down, which created a danger of food being aspirated into their lungs; excessive use of psychotropic drugs coupled with unsafe storage and administration of drugs; mentally retarded children being cared for by other mentally retarded children; confining children to cribs as virtual cages; discretion given to ward attendants to use restraints as needed; in one institution, an administrator who abused children by hitting them with her hand or a soup ladle and who tied one child to her bed or kept her in a high chair all day; lack of programs of physical care and stimulation so that children actually regressed while in the facilities.

The court's order required the State of Louisiana to assure that out-of-state facilities in which children were placed meet minimum standards of care and treatment and ordered the State to remove children from the worst facilities.

The United States also intervened in a case involving the Pennhurst State School and Hospital, located in Spring City, Pa., *Halderman, et al.* v. *Pennhurst State School and Hospital, et al.*, C.A. No. 74-1345 (E.D. Pa.) A residential institution for the mentally retarded, Pennhurst at the time of trial housed approximately 1,230 persons, many of them children. The following are examples of the abuse suffered by children at Pennhurst as found by the district court:

In 1972, an 11-year-old resident strangled to death when tied in a chair in "soft" restraints.

One of the named plaintiffs, admitted when she was 12 years old, had 40 reported injuries on her medical records in the 11 years she was at Pennhurst, including the loss of several teeth, a fractured jaw, fractured fingers and a toe, and numerous lacerations, cuts, scratches, and bites. Although she had a limited vocabulary at the time of her admission, she was no longer speaking at the time of trial.

One parent testified that in 7 years of weekly visits to her son, there were only four occasions on which he was not injured. She reported at trial that she had recently observed cigarette burns on his chest.

Another child was hospitalized for 2 weeks because of head and face injuries received as a result of a beating by another resident.

A 17-year-old blind and retarded girl who could walk was found by her parents strapped to a wheelchair by a straightjacket. She had experienced regression while at Pennhurst as a result of a lack of activities and spent most of her time sitting and rocking. The children at Pennhurst were also subjected to the general poor conditions in the institution which affected the adult residents as well such as the fact that routine housekeeping services were not available during evenings and weekends with the result that urine and feces were commonly found on the ward floors during these periods. There were often outbreaks of pinworms and other infectious diseases. The court found that "obnoxious odors and excessive noise permeate the atmosphere at Pennhurst" and that "such conditions are not conducive to habilitation," Opinion, supra, at p. 32. As in the Texas institutions in the *Gary W.* case, the court also found excessive use of psychotropic drugs as a control mechanism.

I might say parenthetically that I personally argued for the United States before the Third Circuit Court of Appeals earlier this month urging affirmance of the court's ruling in the *Pennhurst* case because of the great importance we attach to a suit of this kind.

Conditions equally atrocious were found to exist in the Willowbrook State School for the Mentally Retarded in New York. The United States participated in the Willowbrook litigation as litigating amicus curiae, and the case was mentioned in connection with congressional consideration of the Bill of Rights for the Developmentally Disabled. The failure of the staff at Willowbrook to protect the physical safety of the children housed there is evidenced by the testimony of parents that their children had suffered loss of an eye, the breaking of teeth, the loss of part of an ear bitten off by another resident, and frequent bruises and scalp wounds * * * 357 F. Supp., supra, at 756. During the trial the United States presented evidence of severe skill regression, loss of IQ points, and loss of basic physical abilities such as walking, during the time that the children were housed in what was known as the Baby Complex at Willowbrook. The average 11-year-old child in the Complex weighed 45 pounds, as compared to the weight of an average 11-year-old of 80 pounds.

Turning to another type of facility, the United States participated as litigating amicus curiae in *Morales* v. *Turman*, by order of the court, to assist in determining the facts concerning the Texas state juvenile reformatories in which minors adjudged delinquent were involuntarily committed.

The district court in that case found a climate of brutality, repression, and fear, 364 F. Supp. at 170. Correctional officers at the Mountain View State School for Boys administered physical abuse including slapping, punching, and kicking of residents, some of whom had committed only such "status" offenses as truancy or running away from home. An extreme form of physical abuse used at the facility was known as "racking" and consisted of requiring the inmate to stand against the wall with his hands in his pockets while he was struck a number of times by blows from the fists of correctional officers.

Another form of abuse found by the court was the use of tear gas in situations where no riot or other disturbance was imminent. One inmate was tear-gassed while locked in his cell for failure to work, another was gassed for fleeing from a beating he was receiving, and another was gassed while being held by two 200 pound correctional officers.

Juveniles were sometimes confined in security facilities consisting of small rooms or cells, for up to 1 month, for conduct not seriously disruptive or threatening to the safety of other persons or valuable property. Expert witnesses testified that such solitary confinement is an extreme measure which should only be used in emergencies to calm uncontrollably violent behavior. Experts agreed that when a child is left entirely alone for long periods, the resulting sensory deprivation can be harmful to mental health.

In addition to the harmful effects of the solitary confinement, inmates in some security facilities were required to perform repetitious make-work tasks, such as pulling up grass without bending their knees or buffing a floor for hours with a rag.

Of necessity, I am able today to give the subcommittee only a few illustrative examples of abuse of institutionalized children, and I invite you to examine some of the reported court decisions to which I have referred, the citations to which are given in my written statement. I have confined my examples today to those which have been found in cases already decided rather than from cases which are presently pending in the courts. I wish to emphasize that by mentioning these cases I do not intend to single out the States involved for special reproach. We have seen similar conditions in 12 cases from 11 other States.

EXTENT OF THE PROBLEM

That brings me to the second issue which I was asked to address today—the Department's perception of the extent of the problem.

I think it would be safe to say that abuse of children in institutions is a widespread and serious problem, using the broad definition of child abuse contained in the Child Abuse Prevention and Treatment Act to which I referred earlier. Just judging from the cases which have been, or are being litigated and from our investigation of other institutions in which suits by the Attorney General have been dismissed for lack of statutory authority, practices which deny children and adults in institutions of basic constitutional rights are quite widespread. It is that perception which led the Department to support legislation which would authorize the Attorney General to initiate suits where they are most needed rather than having to wait until private litigants have brought suits in which we can seek to participate.

REMEDIES FOR ABUSE OF CHILDREN IN INSTITUTIONS

The third area I was asked to address today is that of effective methods for dealing with institutional abuse of children. As a representative of a primarily litigating agency, I would not hold myself out as an expert on this issue. What I can tell you is that, when the Department of Justice represents the interests of the United States in cases dealing with abuse of children in institutions, we investigate to find the facts concerning each institution and employ persons who are experts in the substantive areas to give opinions about what is wrong and what can or should be done about it. We approach the question of remedy on a case-by-case basis, and ask the courts to take the remedial measures which are appropriate to the conditions which it has found to exist.

What I would like to do, briefly, is to give an overview of the kinds of relief which have been ordered by the courts to address some of the types of abuse which I spoke about earlier.

For instance, courts have enjoined the use of medication as a punishment, for the convenience of the staff, as a substitute for programing, or in quantities that interfere with the residents' functioning. Similarly, limitations have been placed on the use of mechanical restraints so that they are used only when necessary to prevent injury to the individual resident or others or to promote physical functioning, that restraints may be used only upon the order of a qualified professional for a specified time and renewed only by the professional, and that the person in restraints must be checked at regular intervals to prevent harm from occurring.

Institution officials have been ordered to take every precaution to see that the buildings in which persons reside are kept clean and conducive to good health. Wheelchairs must be provided for those residents who require them. The feeding of residents while they are lying flat has been prohibited because of the dangers of aspiration. Medical and other health-related services have been required to be provided, and increased security procedures have been required to protect residents from injury.

In the mental health area, the courts have in some cases concluded that the large, isolated institutions which have been in use since the mid-19th century, do not comport with current generally accepted professional standards of care and that persons confined therein should be evaluated on an individual basis for appropriate placement in community-based facilities. That was indeed the finding of the trial court in the *Pennhurst* case. Thus, these courts have ordered the phasing out of the institutions and have provided for some of the measures I described above, as interim relief.

In the context of juvenile detention facilities, the courts have prohibited physical abuse of residents; the use of tear gas as a punitive measure—one of the points the chairman made reference to just a few minutes ago—the unlimited use of solitary confinement; forcing children to remain silent for long periods of time and, for those whose mother-tongue is some other language, requiring them to speak only English.

Racial segregation of juveniles has been prohibited.

When juveniles are placed in solitary confinement, courts have required that counselling be provided and that they be visited at least once a day by a case worker or a nurse.

Make-work assignments have been forbidden.

Institutions have been required to screen their employees to eliminate persons who are potentially abusive to children.

These are illustrative of some effective methods of dealing with particular kinds of abuse of children in institutions. As stated earlier, each case must be approached on its own facts.

I would like to leave you with one thought about the problem which is the subject of these hearings. Children in institutions are unable to articulate their rights and to use the courts to redress deprivations of those rights. It is unfortunate that resort to the legal sysem has been increasingly necessary to secure the basic rights for institutionalized persons to which all citizens are entitled. However, while that forum is needed, I believe that the United States, through the Attorney General, can be an effective advocate for those unable to speak for themselves, and I hope that Congress will enact legislation within the next few months which will provide a firm basis for fulfilling the commitment of the United States to constitutional treatment of all institutionalized persons.

That completes my prepared remarks, Mr. Chairman, and I would be happy to respond or answer any questions.

Senator CRANSTON. Thank you very much for your very responsive, excellent, and helpful testimony. You have added to the list of horrors that we are determined to learn all we can about and then deal with.

I am in total agreement with your closing thought on the peculiar inability of children in institutions to articulate their rights and to use the courts to redress deprivations of those rights. Enactment of S. 10 would enable the United States, through the Attorney General, to be an effective advocate for those unable to speak for themselves. I intend to work hard with Senator Bayh to move that measure forward during this Congress.

However, I believe that advocacy by the Attorney General under the authority provided in S. 10 should not be the only or even the prime effort taken by the Federal Government to assure that institutionalized children are not abused and neglected.

Do you agree with that?

Mr. DAYS. Yes; I do, Senator. Contrary to some opinions, we do not think that litigation is the be all and end all with respect to these complex problems.

What we would hope to see is a melding of these two techniques, litigation and funding, some type of Federal participation so that we can deal with these very difficult problems.

Senator CRANSTON. In order to determine how and when to intervene on behalf of institutionalized children, have you coordinated your work with HEW?

Mr. DAYS. We have to a certain extent. But I think I would have to be candid in saying that the nature and level of cooperation has not been what I had hoped it would be. I am happy to say, however, that Arabella Martinez and I have been talking and working very hard to develop better lines of coordination and communication. I believe we need the expertise of HEW. We need guidance of where litigation technique can be most effective.

Senator CRANSTON. How does Justice generally get involved in particular cases?

Mr. DAYS. Well, as things presently stand, the Senator is aware of our difficulty with initiating suits as a result of the *Solomon* decision. The consequence has been essentially to intervene in cases or participate as a litigating friend of the court. Generally this comes about at the request of the Federal district judges who find themselves confronted with a complex litigation involving a number of issues without parties before it that can assist it in identifying the nature of the problem and helping the court devise appropriate remedies.

Senator CRANSTON. Many of the children in institutions are in institutions that are financed by Federal funds. Some of those are private rather than public institutions.

Mr. DAYS. That is correct.

Senator CRANSTON. Under S. 10, will the Department be authorized to institute or intervene in legal actions on behalf of children that are in a private, not a public setting, if they are supported by Federal funds?

Mr. DAYS. It is my understanding of S. 10, as it is presently drafted, that the determination of whether we can go into private facilities would depend upon traditional analyses of what constitutes State action. In other words, if there is a sufficiently strong nexus between a State government or a locality and a so-called private institution, the Attorney General will be able to reach that. It is my understanding that these institutions which are purely private, that S. 10 would not or does not make clear that we would have that authority.

Senator CRANSTON. Is Federal funding sufficient in itself to give you a basis?

Mr. DAYS. It was our thought that Federal funding would serve to support what we had claimed was inherent authority on the part of the Attorney General to deal with some of these problems, and the courts have not accepted that.

The *Solomon* court specifically rejected that argument.

Senator CRANSTON. Is there any appropriate way to provide you with authorities you lack so that you can intervene on behalf of children, where you may feel excluded presently?

Mr. DAYS. Insofar as purely private institutions are concerned, Senator?

Senator CRANSTON. Should we clarify anything in S. 10 that would give you the authority you need? First, where there is Federal support, is further clarification needed?

Mr. DAYS. I think where it indicates that there is a violation of Federal statute and the statute is the source of funding to institutions, that would provide us with adequate basis for going to deal with some of these problems; yes.

Senator CRANSTON. With or without funding?

Mr. DAYS. Well, it should depend upon the nature of the statute. If the statute was designed to reach private institutions, I think that might serve as a basis for our intervention. It would depend upon the statute at issue.

Senator CRANSTON. As introduced, S. 10 includes a "whistleblower" provision. I believe the whistleblower provision is extremely important in assuring that institutions are operating in a humane fashion. Other witnesses, including such groups as the National Organization of Child Care Workers' Associations, have expressed concern over the need to protect workers from reprisals. What steps do you see as feasible on the Federal level to assure to the maximum extent possible that workers who report circumstances like those of concern to us will be protected if they do so?

Mr. DAYS. Well, Senator, we have had some experience with a comparable provision under title VII, employment discrimination provisions, in which it constitutes a violation of title VII to intimidate someone who is taking action to report a violation of laws with respect to antidiscrimination and employment.

I think our experience with that provision would lead us to believe that we could reach some of the people who might otherwise be subjected to reprisals under provisions such as that in S. 10.

Senator CRANSTON. Can you tell us how high a priority the administration places on enactment of S. 10 and the assurance of appropriate levels of funding so that the authorities can be exercised?

Mr. DAYS. Well, I can speak with great confidence on behalf of the Attorney General who has identified S. 10 and H.R. 10 as one of the major priorities of the Justice Department's legislative program. I am confident also that the administration fully supports the legislation as well. We pressed very hard, as the Senator knows, in the last session to get this statute enacted and I think the Senate and the House can expect that in this session we will be working very hard also.

Senator CRANSTON. This next question, if you can answer now, fine—and I prefer an answer now if you can, but I would like for you to answer it for the record, if you cannot. What we would like to know is whether the institutions were receiving Federal support and, if so, what steps the Justice Department took to report its activities with regard to the institution to the funding Federal agency and what steps the Justice Department took to follow up on the other agency's actions pursuant to that report?

Mr. DAYS. I can speak with some knowledge about the Pennhurst situation. There we had a number of discussions with officials at HEW about continued funding of the Pennhurst facility by the Department of HEW and tried to determine to what extent HEW had been attempting to correct some of the abuses that we had found.

I think what we determined was that HEW had tried time and again to obtain compliance and to obtain changes in conditions and was consistently put off, with promise by the Commonwealth of Pennsylvania that changes would be made, only to find the next time around at the next inspection that very little had changed.

I think it is reflective of the problem that agencies like HEW often have. The funding is going to maintain mentally retarded adults and children, and the question: Should the cutoff of funds approach be used under the circumstances or should litigation be used to try to deal with some of these problems?

It is a hard problem for HEW, but it is a great embarrassment, it seems to me, to the U.S. Government to be in a case on both sides, and it often appears that way in some of our litigation, and the courts and certainly the States have not missed opportunities to point out what appears to be an inconsistency.

I think it is true that these other institutions have also received Federal funding.

Senator CRANSTON. Do you have at hand specifics on whether those you cited have Federal funding?

Mr. DAYS. I do not.

Senator CRANSTON. You can submit that?

Mr. DAYS. I can, only with respect to Pennhurst.

Senator CRANSTON. Is there a written departmental policy on such reporting and followup?

Mr. DAYS. In the Department of Justice, Senator?

Senator CRANSTON. Yes, where you would report to the funding agency the facts?

Mr. DAYS. There is not.

Senator CRANSTON. Do you think there should be?

Mr. DAYS. Absolutely. I think, Senator, that where our authority to participate in these cases is in somewhat a state of limbo, and it is very hard to establish provisions that have some integrity.

Senator CRANSTON. We can explore with you what steps need to be taken and make sure you have that authority.

Mr. DAYS. Yes.

Senator CRANSTON. I would appreciate it if you could remain, if you can—I do not know what your schedule is—for as much of HEW's testimony as possible. I may have some written questions for you, and I would like the answers back within 10 days if possible.

Mr. DAYS. If I could make just one more point on the question of cooperation between HEW and the Department of Justice. One of the things that we have been attempting to do with HEW is assist it in developing firmer assurances of compliance with Federal regulations with recipients from Federal funds. Generally, the situation now is assurances are very weak or very uncertain and indefinite in terms of what the Government expects from recipients of Federal funds.

As a consequence, we have not been able to proceed against institutions that receive Federal funds and what we would like to do in conjunction with pressing for explicit authority is to make clear that the Federal Government can act on some of these assurances where a funding agency finds there has been noncompliance and the Attorney General has given explicit authority to work to that end.

Senator CRANSTON. Thank you. Please also give us for the record the ages of children being abused in the cases you cited to us.

Mr. DAYS. I will, Senator.

Senator CRANSTON. Thank you very very much for your helpful testimony.

Mr. DAYS. Thank you.

[The prepared statement of Mr. Days follows:]

TESTIMONY OF DREW S. DAYS, III BEFORE THE SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT, COMMITTEE ON HUMAN RESOURCES, U. S. SENATE

JANUARY 24, 1979

I thank the Subcommittee for this opportunity to appear today and to testify about a subject which has been of great concern within the Department of Justice - the abuse of children in institutions.

As defined in the Child Abuse Prevention and Treatment Act, 42 U.S.C. 5101-5106, child abuse and neglect means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person responsible for the child's welfare under circumstances which harm or threaten the child's health or welfare. When this legislation was enacted in 1974, the definition was intentionally written broadly enough to take into acount the fact that, for many of our nation's children, the person responsible for their welfare is employed by some kind of institution. As Chairman Cranston's invitation to testify noted, the Department of Justice has, since 1971, been involved as an intervenor or litigating amicus curiae in a number of cases concerning the constitutional rights of confined persons, and in several of those cases there has been substantial evidence of abuse of children, as defined in the legislation which is the subject of these hearings.

As the Chairman also noted, legislation was under consideration during the prior Congress, and has been introduced in this Congress, to give the Attorney General explicit authority to institute suits against particular classes of institutions where he has reasonable grounds to believe that persons are being deprived of their constitutional rights. I am speaking of S. 10 and H.R. 10, which were introduced on January 15, 1979.*/ When I testified before the Senate and House subcommittees having jurisdiction over the bills which were under consideration in the prior Congress, I stated that there were two reasons why such authorizing legislation was necessary. The first is that the experience of the Department in the litigation to which I referred earlier has demonstrated that basic constitutional and federal statutory rights of persons confined in institutions are being violated on such a systematic and widespread basis to warrant the attention of the federal government. The second reason why an authorizing statute is needed stems from the fact that some courts have held that the federal government lacks the power to bring such suits absent authorization from Congress.*/ One court has even suggested that the United States lacks the requisite standing to intervene in an ongoing private suit.**/ While the United States is continuing to participate in litigation where the courts have allowed, the future is uncertain without passage of S. 10 and H.R. 10.

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*/ The corresponding bills for the 95th Congress were S. 1393 and H.R. 9400.

I have been asked to testify specifically today about the abuse of children in institutions with which the Department of Justice is familiar through its litigation, our perception of the extent of the problem, and any suggestions for effective methods of dealing with institutional abuse of children.

Experience of the Department of Justice

Beginning with our experience, the Department has participated in cases involving several kinds of institutions in which persons under eighteen years of age are confined, including facilities for mentally ill and mentally retarded persons and juvenile detention facilities. In those cases, the following types of abuses against children have been found to have occurred.

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*/ United States v. Solomon, 419 F. Supp. 358 (D. Md. 1976), aff'd, 563 F.2d 1121 (4th Cir. 1977); United States v. Mattson, No. CV74-138-BU (D. Mont.), appeal argued November 8, 1978, No. 76-3568 (9th Cir.).

**/ Alexander v. Hall, C.A. No. 72-209 (D. S.C.), order of June 16, 1978.

In a case styled Gary W. and United States v. Stewart, C.A. No. 74-2412-C (E.D. La.), the federal district court found that the State of Louisiana had placed delinquent and dependent children in private care facilities in the State of Texas where in some cases children were being abused and overdrugged and in which treatment was inadequate. When the medical experts employed by the United States in its capacity as plaintiff-intervenor visited a private child care facility in Houston, Texas, they found a 7-year old severely mentally retarded boy in such a malnourished state that he was near death. We sought and obtained from the district court an emergency order requiring Louisiana state officers to remove the child from the facility and to transport him to a nearby medical center.*/ I am happy to report that his life was saved. After trial of the case, the court entered an order detailing the following conditions found in the private facilities in Texas:**/

-- children tied, handcuffed or chained together or to fixtures as a means of control and discipline;

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*/ Order of October 29, 1975.

**/ Order of July 26, 1976.

-- children being fed while lying down, which created a danger of food being aspirated into their lungs;

-- excessive use of psychotropic drugs coupled with unsafe storage and administration of drugs;

-- mentally retarded children being cared for by other mentally retarded children;

-- confining children to cribs as virtual cages;

-- discretion given to ward attendants to use restraints as needed;

-- in one institution, an administrator who abused chidren by hitting them with her hand or a soup ladle and who tied one child to her bed or kept her in a high chair all day;

-- lack of programs of physical care and stimulation so that children actually regressed while in the facilities.

The court's order required the State of Louisiana to assure that out-of-state facilities in which children were placed meet minimum standards of care and treatment and ordered the state to remove children from the worst facilities.

The United States also intervened in a case involving the Pennhurst State School and Hospital, located in Spring City, Pennsylvania, Halderman, et al., v. Pennhurst State School and Hospital, et al., C.A. No. 74-1345 (E.D. Pa.). A residential institution for the mentally retarded, Pennhurst at the time of trial housed approximately 1230 persons, many of them children. The following are examples of the abuse suffered by children at Pennhurst as found by the district court.*/

-- In 1972, an eleven year old resident strangled to death when tied in a chair in "soft" restraints.

-- One of the named plaintiffs, admitted when she was twelve years old, had 40 reported injuries on her medical records in the eleven years she was at Pennhurst, including the loss of several teeth, a fractured jaw, fractured fingers and a toe and numerous lacerations, cuts, scratches and bites. Although she had a limited vocabulary at the time of her admission, she was no longer speaking at the time of trial.

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*/ Opinion and Order of December 23, 1977.

-- One parent testified that in seven years of weekly visits to her son, there were only four occasions on which he was not injured. She reported at trial that she had recently observed cigarette burns on his chest.

-- Another child was hospitalized for two weeks because of head and face injuries received as a result of a beating by another resident.

-- A 17 year old blind and retarded girl who who could walk was found by her parents strapped to a wheelchair by a straightjacket. She had experienced regression while at Pennhurst as a result of a lack of activities and spent most of her time sitting and rocking.

The children at Pennhurst were also subjected to the general poor conditions in the institution which affected the adult residents as well such as the fact that routine housekeeping services were not available during evenings and weekends with the result that urine and feces were commonly found on the ward floors during these periods. There were often outbreaks of pinworms and other infectious diseases. The court found that "[o]bnoxious odors and excessive noise permeate the atmosphere at Pennhurst" and that "[s]uch conditions are not conducive to habilitation," Opinion, supra, at p. 32. As in the Texas institutions in the Gary W. case, the court also found excessive use of psychotropic drugs as a control mechanism.

Conditions equally atrocious were found to exist in the Willowbrook State School for the Mentally Retarded in New York. The United States participated in the Willowbrook litigation as litigating amicus curiae,*/ and the case was mentioned in connection with Congressional consideration of the Bill of Rights for the Developmentally Disabled.**/ The failure of the staff at Willowbrook to protect the physical safety of the children housed there is evidenced by the testimony of parents that their children had suffered

> loss of an eye, the breaking of teeth, the loss of part of an ear bitten off by another resident, and frequent bruises and scalp wounds * * *.

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*/ New York State Association for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D. N.Y. 1973) and NYSARC & Parisi v. Carey, 393 F. Supp. 715 (E.D. N.Y. 1975) (consent decree).

**/ 121 Cong. Rec. 29820 (1975).

357 F. Supp., supra, at 756. During the trial the United States presented evidence of severe skill regression, loss of IQ points, and loss of basic physical abilities such as walking, during the time that the children were housed in what was known as the Baby Complex at Willowbrook. The average eleven year old child in the Complex weighed 45 lbs. as compared to the weight of an average eleven year old of 80 lbs.

Turning to another type of facility, the United States participated as litigating amicus curiae in Morales v. Turman,*/ by order of the court, to assist in determining the facts concerning the Texas state juvenile reformatories in which minors adjudged delinquent were involuntarily committed.

The district court in that case found a climate of brutality, repression, and fear, 364 F. Supp. at 170. Correctional officers at the Mountain View State School for Boys administered physical abuse including slapping, punching, and kicking of residents, some of whom had committed only such "status" offenses as truancy or running away from home. An extreme form of physical abuse used at the facility was known as "racking" and consisted of requiring the inmate to stand against the wall with his hands in his pockets while he was struck a number of times by blows from the fists of correctional officers.

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*/ 364 F. Supp. 166 (E.D. Tex. 1973) and 383 F. Supp. 53 (E.D. Tex. 1974); rev'd for absence of a three-judge court, 535 F.2d 864 (5th Cir. 1976); rev'd and remanded for further proceedings, 430 U.S. 322 (1977); 562 F.2d 993 (5th Cir. 1977) (remanded for evidentiary hearing concerning whether there are changed circumstances).

Another form of abuse found by the court was the use of tear gas in situations where no riot or other disturbance was imminent. One inmate was tear-gassed while locked in his cell for failure to work, another was gassed for fleeing from a beating he was receiving, and another was gassed while being held by two 200 lb. correctional officers.

Juveniles were sometimes confined in security facilities consisting of small rooms or cells, for up to one month, for conduct not seriously disruptive or threatening to the safety of other persons or valuable property. Expert witnesses testified that such solitary confinement is an extreme measure which should only be used in emergencies to calm uncontrollably violent behavior. Experts agreed that when a child is left entirely alone for long periods, the resulting sensory deprivation can be harmful to mental health.

In addition to the harmful effects of the solitary confinement, inmates in some security facilities were required to perform repetitious make-work tasks, such as pulling up grass without bending their knees or buffing a floor for hours with a rag.

Of necessity, I am able today to give the Subcommittee only a few illustrative examples of abuse of institutionalized children, and I invite you to examine some of the reported court decisions to which I have referred, the citations to which are given in my written statement. I have confined my examples today to those which have been found in cases already decided rather than from cases which are presently pending in the courts. I wish to emphasize that by mentioning these cases I do not intend to single out the states involved for special reproach. We have seen similar conditions in twelve cases from eleven other states.

Extent Of The Problem

That brings me to the second issue which I was asked to address today--the Department's perception of the extent of the problem.

I think it would be safe to say that abuse of children in institutions is a wide-spread and serious problem, using the broad definition of child abuse contained in the Child Abuse Prevention and Treatment Act to which I referred earlier. Just judging from the cases which have been or are being litigated and from our investigation of other institutions in which suits by the Attorney General have been dismissed for lack of statutory authority, practices which deny children and adults in institutions of basic constitutional rights are quite widespread. It is that perception which led the Department to support legislation which would authorize the Attorney General to initiate suits where they are most needed rather than having to wait until private litigants have brought suits in which we can seek to participate.

Remedies For Abuse of Children In Institutions

The third area I was asked to address today is that of effective methods for dealing with institutional abuse of children. As a representative of a primarily litigating agency, I would not hold myself out as an expert on this issue. What I can tell you is that, when the Department of Justice represents the interests of the United States in cases dealing with abuse of children in institutions, we investigate to find the facts concerning each institution and employ persons who are experts in the substantive areas to give opinions about what is wrong and what can or should be done about it. We approach the question of remedy on a case-by-case basis, and ask the courts to take the remedial measures which are appropriate to the conditions which it has found to exist.

What I would like to do, briefly, is to give an overview of the kinds of relief which have been ordered by the courts to address some of the types of abuse which I spoke about earlier.

For instance, courts have enjoined the use of medication as a punishment, for the convenience of the staff, as a substitute for programming, or in quantities that interfere with the residents' functioning. Similarly, limitations have been placed on the use of mechanical restraints so that they are used only when necessary to prevent injury to the individual resident or others or to promote physical functioning, that restraints may be used only upon the order of a qualified professional for a specified time and renewed only by the professional, and that the person in restraints must be checked at regular intervals to prevent harm from occurring.

Institution officials have been ordered to take every precaution to see that the buildings in which persons reside are kept clean and conducive to good health. Wheelchairs must be provided for those residents who require them. The feeding of residents while they are lying flat has been prohibited because of the dangers of aspiration. Medical and other health-related services have been required to be provided, and increased security procedures have been required to protect residents from injury.

In the mental health area, the courts have in some cases concluded that the large, isolated institutions which have been in use since the mid-nineteenth century do not comport with current generally accepted professional standards of care and that persons confined therein should be evaluated on an individual basis for appropriate placement in community-based facilities. Thus, these courts have ordered the phasing out of the institutions and have provided for some of the measures I described above, as interim relief.

In the context of juvenile detention facilities, the courts have prohibited physical abuse of residents; the use of tear gas as a punitive measure; the unlimited use of solitary confinement; forcing children to remain silent for long periods of time and, for those whose mother-tongue is some other language, requiring them to speak only English.

Racial segregation of juveniles has been prohibited.

When juveniles are placed in solitary, courts have required that counselling be provided and that they be visited at least once a day by a case worker or a nurse.

Make-work assignments have been forbidden.

Institutions have been required to screen their employees to eliminate persons who are potentially abusive to children.

These are illustrative of some effective methods of dealing with particular kinds of abuse of children in institutions. As stated earlier, each case must be approached on its own facts.

I would like to leave you with one thought about the problem which is the subject of these hearings. Children in institutions are peculiarly unable to articulate their rights and to use the courts to redress deprivations of those rights. It is unfortunate that resort to the legal system has been increasingly necessary to secure the basic rights for institutionalized persons to which all citizens are entitled. However, while that forum is needed, I believe that the United States, through the Attorney General, can be an effective advocate for those unable to speak for themselves, and I hope that Congress will enact legislation within the next few months which will provide a firm basis for fulfulling the commitment of the United States to constitutional treatment of all institutionalized persons.

Senator CRANSTON. We will now hear from Arabella Martinez, Assistant Secretary for Human Development Services of HEW.

STATEMENT OF HON. ARABELLA MARTINEZ, ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY BLANDINA CARDENAS RAMIREZ, COMMISSIONER FOR CHILDREN, YOUTH, AND FAMILIES; AND HERSCHEL SAUCIER, ASSOCIATE COMMISSIONER, OFFICE OF SERVICES FOR CHILDREN AND YOUTH

Ms. MARTINEZ. Mr. Chairman, I am Arabella Martinez, Assistant Secretary for Human Development Services. With me today is Blandina Cardenas Ramirez, Commissioner for Children, Youth, and Family.

Also with me today is Herschel Saucier, who is Associate Commissioner for the Office of Services for Children and Youth. Mr. Saucier has a distinguished and long record in the field of child welfare in Georgia, and we are very pleased to have him aboard with us.

I want to thank you for providing this opportunity to testify on the critically serious problem of the abuse and neglect of children in institutions.

These hearings are testimony to a growing public concern for the 360,000 children who live in residential institutions, temporary and long-term shelters, detention centers and homes; centers for the mentally retarded and developmentally disabled, and group homes; and for the 394,000 children who have been placed in foster family care. These hearings specifically are testimony to a deepening concern that some of these children may be victims of maltreatment in the very institutions that are established with public and private financial support and under governmental regulation to serve their needs.

Mr. Chairman, you have asked that I address three broad questions. First, what do we know about the abuse and neglect of children in institutions? Second, what is the Federal Government doing to address this problem? And third, what do we recommend should be done?

PRESENT KNOWLEDGE ABOUT INSTITUTIONAL CHILD ABUSE AND NEGLECT

In using the term institutional abuse before this subcommittee, I am addressing only child abuse and neglect which occurs in residential institutions; my testimony does not address maltreatment in schools, day care centers, recreation programs or other nonresidential settings.

We know that approximately 1 percent of the child population—about 754,000 children—are in some form of residential care. While the number seems small, the public responsibility for these particular children is great. In many cases, these children are in institutional settings because society, acting through public agencies and courts, has determined that their care and nurture cannot be provided by their families and has intervened to provide it in place of their families. In other cases, these children are in institutional care because their families have recognized their special physical or emotional handicaps and have chosen or been forced by these circumstances to seek alternative ways to care for their children.

The Federal role is a limited one since most such institutions are State or privately operated and operate under existing State and local laws and regulations. Because of this fact, it is the role of State legislative bodies and regulatory agencies to determine and implement the appropriate enforcement of child abuse and neglect laws and child protection measures governing their operation. However, the Department is dealing with this problem within its legislated role, which is primarily one of setting standards as conditions of limited financial support, technical assistance, and advocacy. I will talk more about these efforts later.

As to our knowledge about the actual extent, or the exact nature of institutional child abuse and neglect in the United States, it is abysmally minimal. To a large degree this is so because, as I mentioned before, the administrative, regulatory and proprietarial systems which have charge of such institutions are generally within the control of the States. The problems that turn into the abuse of children in institutions are best known from articles, stories, and exposes in news articles, on TV, and from Ken Wooden's book, "Weeping in the Playtime of Others"; and also from the court cases so excellently litigated by the Department of Justice.

We read and hear of specific instances of dehumanizing conditions, lack of staff, inadequate facilities, absence of basic resources, indifferent attitudes, and administrative inadequacies that often result in a child or children being victimized, sometimes irreparably harmed, or in rare cases, even killed. Yet we have only meager data on the nature, incidence and severity of such residential child abuse and neglect, and no definitive statistics. For example, the validated reports collected by the American Humane Association for 1977 included 81 reports from 26 States involving an employee of a residential institution.

Nevertheless, from this limited information, and based on the specific instances that have come to our attention, we are led to suspect that we are only learning about a very small portion of the problem and, in fact, we are only seeing the tip of the iceberg.

From the individual occasions of known child maltreatment in institutions, we know that, at the very minimum, procedures to provide protective services to children who depend on care in these settings are as important as such procedures are for children at risk of maltreatment at the hands of their parents.

HEW ACTIVITIES TO PREVENT INSTITUTIONAL CHILD ABUSE AND NEGLECT

The Child Abuse, Prevention, and Treatment Act of 1974 which created the National Center on Child Abuse and Neglect gave the Federal Government responsibility primarily for the prevention and treatment of abuse within the family. The responsibility of the National Center extends to institutional abuse. Its role is one of technical assistance and active encouragement to the States in the areas of prevention, identification, and the remediation of child abuse and neglect in residential institutions.

In fulfilling its responsibilities toward institutionalized children, the Center has focused on four primary areas: Reporting, investigation, and correction procedures, model State legislation; cosponsorship of a national conference on institutional abuse of children; and demonstration grants on investigation and correction of institutional abuse.

Let me describe each of these efforts and then turn to other activities ongoing within the Department.

REPORTING, INVESTIGATION, AND CORRECTIVE PROCEDURES

One requirement for eligibility for State grants is that the State must develop procedures, with the force of State law or administrative regulation, to handle the receipt of reports of known or suspected institutional child abuse and neglect, its investigation and correction. As a part of the act and spelled out in Federal regulations which implement the act, the State must provide for the reporting of known or suspected incidents of child abuse and neglect in such a way that the legally authorized investigative agency may not be made responsible for investigating itself where it also is responsible for running the residential program which is under investigation.

In fiscal year 1978, a total of 47 States, and that includes the District of Columbia, the Commonwealth of Puerto Rico, and the Territories, had attained full or conditional eligibility for State grants, and we expect that number to reach 50 during fiscal year 1979. To meet the eligibility requirements as they affect institutional child maltreatment, States have vested investigative authority in various agencies. For example, Vermont directs that all reports involving caregiving agencies administered by the social and rehabilitation services—which is the mandated child protection agency in that State—shall be directed to the secretary of the Agency for Human Services. The secretary then directs an outside investigation and makes recommendations.

MODEL STATE LEGISLATION

To assist States in developing their own child abuse and neglect legislation, the National Center developed a Draft Model Child Protection Act. This was widely distributed for comment to policymakers and professionals in the field. Although still in draft form, it has already been used as a blueprint for enacting legislative amendments by several States. This act includes a section that specifically addresses institutional child maltreatment. That section incorporates requirements for: (1) designation of an independent investigative agency; (2) an official agreement containing procedures for receiving reports, making investigations and taking remedial action; and (3) a means of incorporating information on the progress, findings, and dispositions of investigations into the State's central child protection system. In addition, the act provides for purchase of service agreements between a State's mandated child protection agency and another public or private agency to serve as the officially designated investigative authority in residential cases.

NATIONAL CONFERENCE ON INSTITUTIONAL ABUSE

That conference was a pioneering effort to come to grips with some of the very knotty issues concerning institutional care of children.

The National Center on Child Abuse and Neglect cosponsored, with its region II resource center at Cornell University, a pioneering national conference on the institutional maltreatment of children in June of 1977. Attended by a multidisciplinary-multiagency group of 80, this conference focused on identifying the major issues and areas where change is needed, increasing public and professional concern, and on developing strategies to correct and prevent institutional child maltreatment. A recent report by the Center entitled "Child Abuse and Neglect in Residential Institutions; Selected Readings on Prevention, Investigation and Correction," incorporated the report of the proceedings of the conference along with other materials on the subject.

Major areas of concern identified by conference participants include: size, inadequate staffing, isolation from community and family; need for public awareness; need for expanded regulation of residential institutions; need for appropriate alternatives and support services to reduce unnecessary institutionalization.

Recommendations that emerged from the conference have been and will continue to be useful in shaping policy of the Center. One result has been the development of specific standards addressing institutional abuse which were included in the "draft federal standards for child abuse and neglect prevention and treatment programs and projects." These draft Federal standards were published and distributed for review and comment by the field in March 1978, and are currently being used in program development, even in draft form. We have received more than 70 comments, overwhelmingly positive, which are currently being reviewed as we redraft the standards for final dissemination.

DEMONSTRATION GRANTS

In September 1978, the National Center awarded four demonstration grants on the investigation and correction of child abuse and neglect in residential institutions. Eligibility for these grants was limited to State agencies with legal authority to make investigations and take corrective action. The grantees were chosen by a non-Federal peer review panel.

The grantees are the Utah Division of Family Services, the Massachusetts Office for Children, the District of Columbia Social Rehabilitation Administration, and the New Jersey Division of Youth and Family Services. Each received approximately $80,000 a year for a project period extending 3 years. These demonstration projects will develop procedures for making practical use of the goals embodied in child abuse legislation.

Since representatives of several of the projects will be testifying here this morning, we will simply provide you now with brief descriptions of these four projects:

Utah's project plans to conduct a comprehensive computer search of the relevant professional literature; generate demographic, attitudinal, psychological, and socioeconomic profiles of staff and residents of all types of residential institutions; employe "participant observers" for monitoring behavior and gathering observational data about the types of interactions between and among staff and residents; develop and implement treatment methods; establish multidisciplinary correction action teams for each institution; and develop and validate a system for reporting known and suspected cases of institutional abuse to an independent investigative agency.

Massachusetts' project is creating substate regional visitation-review committees and a statewide task force to address primary prevention; refining licensing and standard-setting functions for the residential placement of children, and refining the mechanisms worked out with the State Department of Welfare for receiving reports and investigating and correcting individual cases.

The District of Columbia's project is initiating a system for allowing residents in the institution to report maltreatment by signing their names to a form and depositing it directly into locked boxes which will be checked daily. These reports, together with staff-initiated "unusual incident reports," will begin an investigative and corrective process that will involve independent investigators, a review panel which will include residents and outside advocates and make recommendations to the Administrator of the Social Rehabilitation Administration. In addition, the project will provide advanced counseling groups for staff to aid them in dealing with staff-child confrontations and problems of discipline.

New Jersey's project is examining and testing three different approaches to advocacy and procedures, using internal, State-administered, and private citizen advocacy systems of investigation. It will also make a major effort at raising awareness of institutional employees of their responsibility to report known and suspected cases of child maltreatment.

These grants were awarded 4 months ago and the projects are still in their startup phases, but they hold promise for serving as models for other States. As part of their dissemination and utilization requirements, the projects will be providing interim reports on the early findings of their work.

In addition to these national center activities, there are a number of other HEW activities which relate to the prevention and correction of abuse and neglect of children in institutions. Let me cite just a few, beginning with the HDS programs.

The President's Committee on Mental Retardation has just drafted a report on the prevention and treatment of child abuse and neglect in institutions for the mentally retarded. This report incorporates material contained in the "Draft Federal Standards for Child Abuse and Neglect Prevention and Treatment Programs and Projects" and has been considered by the committee this past week. PCMR is now planning site visits to institutions in order to focus on accrediting policies, on methods of behavioral control, and on the use—or misuse—of medication. Findings from these visits and the draft report will form a basis for recommendations on how to reduce abuse in institutions for the mentally retarded.

The developmental disabilities program over the past 8 years has provided funding for a contract which developed standards for residential facilities and for the development of training programs in the use of these standards. A training program utilizing these standards is provided by the contractor to institutions for a modest fee. More than 100 workshops in 35 States have been held since 1975.

Since the fall of 1977, DDO has assisted States in creating protection and advocacy programs. Several States have used their own funds to supplement the Federal funds and have created programs focusing specifically upon residential institutions. New Jersey, Illinois, and Michigan have developed programs of residential advocates who work with the State institutions. Delaware, Indiana, and New York are currently organizing their own institutional protection and advocacy systems.

The Children's Bureau has supported the development and use of curricula for the training of residential child caregivers and foster parents.

The runaway youth program, administered by the Youth Development Bureau, provides services for young people who have run away from institutions as well as from their own homes. The program works to correct the conditions affecting the young people who come to the shelters it funds.

The program, to be developed as a result of the Adoption Opportunities Act you sponsored, Mr. Chairman, will assist in alleviating potential abuse of children in institutions by enabling permanent placements to be increased. The model act, the data gathering system, the adoption information exchange and the training and technical assistance activities will provide direction to State and local governments and agencies to aid them in increasing opportunities for adoption.

Under the medicaid program, several requirements have a bearing on child abuse detection and prevention:

Institutions receiving medicaid or medicare payments for long-term care must have in place a "patient bill of rights" which specifically provides that each patient shall be free from mental and physical abuse, and free from chemical and physical restraints, except under certain limited conditions.

Institutions are also subject to medical and professional review requirements under which a team of health professionals annually review each patient's care. In addition, each institution is reviewed annually to insure that it meets certification standards. These reviews provide an opportunity to detect abuse of the patient.

In addition to these HEW activities, I believe the Department of Justice has worked toward deinstitutionalization or more appropriate institutional placement in a number of ways. I defer to Justice for specific comments on those efforts.

RECOMMENDATIONS FOR FUTURE ACTION

Mr. Chairman, this administration has consistently encouraged each State to furnish services directed at the goals of (1) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; (2) securing referral or admission for institutional care when other forms of care are not appropriate; (3) providing services to individuals in institutions. This includes expenditures for administration—including planning and evaluation—and personnel training and retraining directly related to the provision of those services.

We are proposing several different ways to reduce the abuse and neglect of children in institutions. We will again be asking your assistance, Mr. Chairman, in enacting this year's child welfare amendments, which, as you know, are designed to improve the foster care and child welfare systems by requiring protections for the children in care such as case reviews and hearings on the status of their placements. The proposal also stresses the need for permanent placement of children, either through services designed to return them to their families, or through a program of subsidized adoption for children with special needs.

Recognizing that licensing is a primary tool for assuring the protection of children as well as providing a floor of protection against hazards, and a basic level of quality of care below which it is illegal to operate, the Children's Bureau will continue to actively assist States in upgrading and strengthening their licensing programs through:

Publication of materials such as "Licensing—Interaction between the Licensing Agent and Service Providers."

Provision of technical assistance by Children's Bureau staff to individual States.

Inclusion of training for State licensing staff as a priority in awarding grants under section 426.

Development of licensing materials for State use including a model licensing law; guideline licensing requirements for child placing agencies, child care institutions, and foster family homes; and describing the key elements in an effective licensing operation.

In addition, as I mentioned earlier, we have developed a number of recommendations for the States since the legal authority and administrative structures for change are primarily at the State level. There is a strong Federal responsibility for leadership, information dissemination, and advocacy which we have begun in order to better safeguard those children who live in residential institutions.

We welcome the opportunity to work with you and the subcommittee, Mr. Chairman, in encouraging State and local agencies to make the changes needed.

Thank you. I will be happy to answer any questions you may have.

Senator CRANSTON. Thank you very much. I look forward to working with you during the next few months in our renewed efforts to achieve passage of the foster care and adoption reform legislation.

I do have a number of questions for you. But the first one is concerning a matter which I find very, very troubling.

In your prepared statement while you characterize the problem of institutional child abuse as a "serious one," you state "the Federal role is a limited one since most such institutions are State or privately operated and operate under existing State and local laws and regulations."

Mr. Days in his testimony on behalf of the Department of Justice seemed to take a very, very different approach that I find much more appropriate in stating the experience of the Justice Department in their litigation demonstrated that they think "the constitutional and Federal statutory rights of persons confined in institutions are being violated on such a systematic and widespread basis as to warrant the attention of the Federal Government."

Your statement seems to take no account of a totally shocking fact, the tragic fact that although most institutions are State or privately operated, they are supported in many cases with Federal funds.

How on Earth can the Federal Government say it has no responsibility to deal with the situation when Federal funds are paying for that kind of abuse? That is an absolutely unacceptable position for the Federal Government.

Let me go on now to give you some figures that aggravate my disturbance over this and it is a disturbance I feel everyone should feel who is aware of these facts. I recently asked the Congressional Research Service to provide the subcommittee some data on the use of Federal funds to support children in various institutional settings. The preliminary estimates provided by CRS indicate that at least $800 million—almost $1 billion—$800 million was being spent by the Federal Government, almost all by HEW, which you represent here this morning, on children in institutional care. Much of that is going to institutions, I am sure, that treat children well.

But we have strong reason to believe and substantial evidence to convince us that a portion of these funds are going where children are badly abused. That figure, total figure, includes $103 million under title IV–A of the Social Security Act; $37.6 million under the SSI programs; $425 million under medicaid; $140.2 million under title I of the Elementary and Secondary Education Act; $51 million from Federal juvenile delinquency funds; $50 million from Federal nutrition programs.

These estimates do not even include Federal funds under title IV–B or title XX of the Social Security Act because we have been unable so far to get a breakdown on institutional care for children under these programs. So we do not even know how the money is being spent. We do know that 46 States use some amount of title XX funds for residential and institutional care of children. This estimate does not include other programs such as the federally funded developmental disability program, the CHAMPUS program operated under the Department of Defense, or the VA's CHAMPVA program, or any mental health money, crippled children services, nor maternal and child health funds, for which CRS has not yet been able to provide breakdowns. I suspect that the total amount for all these programs will exceed $1 billion in Federal funds each year going into State and private institutional care for children.

How on earth can we take a position that the Federal Government has no responsibility to make sure that children are not being abused with that abuse financed in effect by Federal funding? It seems to me that we have a substantial responsibility to be concerned about protecting the rights, the human rights of these children from brutality and abuse.

Ms. MARTINEZ. Mr. Chairman, let me try to clarify the issue. I did not say the Federal Government did not have responsibility; I said it has limited responsibility. We in HEW have developed a number of initiatives to try to increase our influence among the States with respect to the administration of these programs.

It is a very direct relationship that the Justice Department has when it is asked to go into a court case or when it intervenes.

We do not have that same direct involvement in the actual administration of these programs. Nevertheless, there are within HEW a number of areas in which we are recodifying many of our regulations, including regulations governing foster care. We are recodifying title XX regulations. We are recodifying regulations governing child abuse and neglect, and programs for the developmentally disabled. All of these regulations will provide us a greater ability to influence the way the States administer the program.

The second thing I think is critical here is that we have proposed a major revision in foster care and child welfare services. We are pushing with all of our might to insure that bill gets passed this year. That will result in decreasing the number of children in institutions. It will result in decreasing the number of children who are in institutions all their lives. We expect that that bill with your assistance will get through this time. Also, significant is what the Secretary has done with respect to the medicaid regulations and the monitoring of those. We are doing more monitoring of States now than ever before.

We do have limitations, limitations imposed by legislation, not by regulation. We are not able, for example, to approve the title XX State plan. All we have the capacity to do by law, is to review it. We are not allowed in many cases to intervene directly in situations, not even in terms of the child abuse and neglect law.

We do not get even the reports of abuse directly. We have contracted with the American Humane Association to get those reports, and the States voluntarily submit them to the American Humane Association, and only about 30 of them do. We do not have the legislative authority to require that the data be submitted. And, of course, there are some States that are not even using Federal money for child abuse and neglect programs.

There is not any doubt, and we certainly were not inferring in this testimony that we should not have a role and that we should not increase our role, but I think you need to take a look at the legislative restraints. We in the Department are taking a look at the regulatory restraints.

Senator CRANSTON. Well, obviously, we are not doing enough. I am glad you are seeking to do more. If your legislative authority is inadequate, I think you should suggest to us and we should try to suggest to ourselves ways to give you the appropriate legislative responsibility because it is an intolerable situation as it is presently. Obviously, the Federal Government has great responsibility when so much Federal money is going into it. We do need to know more about the degree of that money, the dimensions of where it is going.

So I would like to ask if you cou'd undertake to develop your own estimate, to the best of your ability, of total Federal dollars going into this and provide it to us for the record.

Neither your testimony nor the Department of Justice give the impression of any ongoing coordination of activities between the two departments. According to Assistant Attorney General Days, there is little coordination between HEW and the Civil Rights Division of the Justice Department looking for the problem of children in institutions. You agree that there is not much coordination?

Ms. MARTINEZ. I believe there could be much greater coordination, and Mr. Days and I have suggested some ongoing activities that we intend to pursue with all vigor.

Senator CRANSTON. I would like to ask and suggest that you both agree to establish an ongoing task force at the Deputy Assistant level to provide for the coordination of activities, and I hope that that can stimulate new and increased efforts in that area. I would appreciate it if you could let us know what is being done by each department, including the level of support and staff allocations for such efforts at coordination.

Ms. MARTINEZ. One thing I should say, Senator, the Leach amendment was passed in the last appropriation. Every single Department has been cut back, and the Office of Human Development Services has received its allocated share of cutbacks as required by law.

Senator CRANSTON. Under HEW's regulations for State grants under the Child Abuse Prevention and Treatment Act, each State receiving child abuse funds is required to provide for the reporting of child abuse and neglect in institutions, and investigations of such reports by an agency independent of the institution. Would you please submit for the record a list of the efforts of each State receiving funds under Public Law 93–247 to meet the requirements for institutional abuse reporting.

I would like to ask what is your assessment of the general quality of compliance of the States with this requirement?

Ms. MARTINEZ. I have asked the Administration for Children, Youth, and Families to take a look at the area of compliance and see if we ought to change our procedures and our regulations with respect to that particular item in the regulations. This is one of the values of these hearings. You learn a lot about problems and issues.

Senator CRANSTON. We hope that that is one of the values, yes.

Can you identify now any State receiving Public Law 93–247 funding which you believe is doing an effective job of monitoring for abuse in institutional settings?

Ms. MARTINEZ. We cannot, but we will get you that information.

[The information referred to follows:]

Question. Can you identify any State receiving Public Law 93–247 funding which you believe is doing an effective job of monitoring for abuse in institutions?

Answer. We believe that the State of New Jersey has made exemplary strides in implementing an effective program to prevent and correct child abuse and neglect in residential institutions. Using a portion of its State grant funds, (provided under the authority of the Child Abuse Prevention and Treatment Act), New Jersey began a program in fiscal year 1978 to provide training for child care workers, to increase public and professional awareness of provisions for reportings, and to carry out the procedures it had developed for making independent investigations.

The rate of reporting has increased by 54 percent in the course of one year. New Jersey's new demonstration grant is making possible more concerted, centralized efforts within the Division of Youth and Family Services to expand training, to increase public awareness, and to improve the efficiency of investigations in cases of known and suspected abuse or neglect.

Senator CRANSTON. Many of the witnesses in our San Francisco hearings and the recommendations arising out of the HEW-supported Cornell Conference on Institutional Treatment of Children suggested the establishment of independent monitoring mechanisms for all Federal programs that fund institutional care for children. What is your opinion of the need for some independent mechanism to monitor the quality of care in institutional settings?

Ms. MARTINEZ. We have just begun on the Office of Developmental Disabilities to create State protection and advocacy programs. We do not yet know their effectiveness in this area. We funded the four projects I mentioned in my testimony to determine what works best and how protection and advocacy systems work best. I think we generally believe that this is a good idea, but we are not sure yet what really works and what really does not work. I have no doubt that it is important to have people from outside the institutions monitoring the institution, but I am not sure yet what the mechanism should be.

Senator CRANSTON. Do you think it would be appropriate to require a certain portion of child welfare funds, for example, title IV–B to be targeted on funding independent monitoring?

Ms. MARTINEZ. I am not sure. I would have to think about that.

Senator CRANSTON. Think about that and give us your thoughts.

Ms. MARTINEZ. I would like to look at that issue.

[The information referred to follows:]

Question. Do you think it would be appropriate to require a certain portion of child welfare funds, for example, Title IV–B, to be targeted on funding independent monitoring?

Answer. We do not believe it would be appropriate to target or earmark funds for independent monitoring at this time. While no funds are earmarked under Title IV–B at this time, the Administration's foster care/child welfare proposal mandates that the States spend a certain proportion of their funds on preventive and restorative services. In addition, this proposal mandates case plans, semiannual case reviews, and state tracking systems for all foster children which we believe will provide a good monitoring system.

Senator CRANSTON. The 1977 Cornell Conference which you sponsored resulted in some short term goal and a long term goal recommendations. Those short term goals included: One, public education campaigns; two, national information collection and dissemination; three, State and local institutional abuse conferences; and four, lobbying and legislative action in various areas, including mandated internal advocacy programs. What sort of followup has taken place for implementation of these recommendations?

Ms. RAMIREZ. We currently have plans, Senator, for another conference to bring together a broader spectrum of individuals and organizations concerned with the well-being of children. That would, in fact, kick off, a broader public awareness campaign. We continue through our child abuse and neglect clearinghouse to focus on this area as a result of what we learned at our Cornell Conference.

Senator CRANSTON. In the past several years both the GAO and HEW audits have uncovered illegal foster care payments. A number of individuals have complained that there has been no followup on these audits and no efforts to recoup illegal expenditures. For example, foster care payments to profitmaking agencies. It was pointed out to the subcommittee in our last hearing that there is a feeling that there was no followup on these audits and that this causes a great deal of disillusionment. I would appreciate it if you could provide for the record a statement of the steps HEW has taken as a result of its own foster care audits in 1976 and the GAO audit in 1977.

One of the participants at the Cornell Conference is quoted in the National Center on Child Abuse and Neglect's summary of those proceedings as saying that most people do not believe what happens to children in institutions and that if the public really knew and understood what was going on inside these institutions, they would not put up with it.

Do you agree with that view? If so, do you think there are things the Federal Government should be doing to increase the awareness of the problem apart from whatever you may do or not to deal with the problem?

Ms. MARTINEZ. Certainly we ought to be trying to increase awareness of the problem. In fact, we are trying to do that. The evidence of increasing awareness is very clear when you look at family abuse of children. We know that there is a greater incidence of reporting now than there used to be.

The 1977 report which is coming out indicates that there is an increase of 36 percent in the incidence of reporting. It seems to me that, as the public becomes more aware, they will do something about it. I would hope that there would be a few people who would——

Senator CRANSTON. If the public was more aware, they would demand something be done about it by those in Government.

Ms. MARTINEZ. I would hope that was true, Senator. I think there have been some changes made already. I think the cases in which the Justice Department has been involved indicated concern on the public's part. My feeling is that we also need, however, to really work with the personnel on the institutions. They need to be made more aware—more aware of their responsibilities and aware of their rights in terms of reporting.

Senator CRANSTON. I agree with you. You may recall that nearly 2 years ago when you testified before the subcommittee on S. 961, the Adoption Opportunities Act, I asked you a question that former Senator Mondale had asked the administration in 1975 when he chaired the predecessor of this subcommittee. Then Senator Mondale asked in 1975 how much money the Federal Government was spending on keeping children with their families and preventing inappropriate foster care as compared to the amount of money the Federal Government expends on keeping children in foster care.

On April 4, 1977, when I asked, you said you had no data and could give only examples of HEW-funded activities. Have you made any progress in finding out the answer?

Ms. MARTINEZ. We have some data. We have data which contradict other kinds of data. That is part of the problem. And the real problem is that we do not have an adequate management information system although improvement of the management information system is something we will undertake as part of our responsibility under the Adoption Opportunities Act. I can tell you that we are moving ahead without any resources to develop a child welfare information system. It is going to be difficult, but we are doing it. We do have some data and I can get it for you. The data are not very encouraging, that of it that I see. It indicates that we spend very little time trying to keep families together and that the States are spending less time trying to reunify them. Part of that may have to do with resources at the State level. But the data are not very encouraging. Preventive and restorative services are major provisions of our child welfare bill.

Senator CRANSTON. $5 million has already been appropriated by the Congress to carry out the new adoption opportunities provisions.

Do I read the President's budget correctly that $5 million more is requested by the administration for fiscal year 1980?

Ms. MARTINEZ. That is correct; sir.

Senator CRANSTON. What will these funds generally be spent for? Give us a detailed breakdown for the record.

Ms. MARTINEZ. Yes. Under the law we have ongoing responsibilities, as you know, in terms of that act, including maintaining a national foster care, data-gathering system, and adoption information exchange. So those are ongoing responsibilities under the law that we would have to maintain.

Senator CRANSTON. I am appreciative of the budget request for funding in that regard. I appreciate your help in that respect.

I have a number of written questions which I will submit to you for responses for the record. You recall that in the last session we had some trouble getting answers back.

Ms. MARTINEZ. We now have a legislative person on board, Senator Cranston.

Senator CRANSTON. If you can give personal attention to them and make sure we do get them back within 10 days, I would appreciate it.

Ms. MARTINEZ. Yes.

Senator CRANSTON. Fine. If you can stay to hear a few of the following witnesses who will be describing some troubling situations, I think it might be helpful.

Thank you very, very much.

Ms. MARTINEZ. Thank you.

[The prepared statement of Ms. Martinez and responses to questions submitted to HEW follow:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

STATEMENT OF

ARABELLA MARTINEZ
ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

SENATE HUMAN RESOURCES COMMITTEE
SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT

CONCERNING
ABUSE OF CHILDREN IN INSTITUTIONS

24 January 1979

Mr. Chairman, Members of the Subcommittee, I am Arabella Martinez, Assistant Secretary for Human Development Services. With me today is Blandina Cardenas Ramirez, Commissioner for Children, Youth and Families. I want to thank you for the opportunity to testify on the serious problem of the abuse and neglect of children in institutions. These hearings are testimony to a growing public concern for the 360,000 children who live in residential instiutions, temporary and long-term shelters, detention centers and homes, centers for the mentally retarded and developmentally disabled, and group homes; and for the 394,000 children who have been placed in foster family care. These hearings specifically are testimony to a deepening concern that some of these children may be victims of maltreatment in the very institutions that are established with public and private financial support and under governmental regulation to serve their needs.

Mr. Chairman, you have asked that I address three broad questions. First, what do we know about the abuse and neglect of children in institutions? Second, what is the Federal government doing to address this problem? And third, what do we recommend should be done?

PRESENT KNOWLEDGE ABOUT INSTITUTIONAL CHILD ABUSE AND NEGLECT

In using the term institutional abuse before this Subcommittee, I am addressing only child abuse and neglect which occurs in residential institutions; my testimony does not address maltreatment in schools, day care centers, recreation programs or other nonresidential settings.

We know that approximately one per cent of the child population -about 754,000 children --- are in some form of residential care. While the number seems small, the public responsibility for these particular children is great. In many cases, these children are in institutional care because society, acting through public agencies and courts,has determined that their care and nurture cannot be provided by their families and has intervened to provide it in place of their families. In other cases, these children are in institutional care because their families have recognized their special physical or emotional handicaps and have chosen or been forced by these circumstances to seek alternative ways to care for their children.

The federal role is a limited one since most such institutions are state or privately operated and operate under existing state and local laws and regulations.

Because of this fact, it is the role of state legislative bodies and regulatory agencies to determine and implement the appropriate enforcement of child abuse and neglect laws and child protection measures governing their operation. However, the Department is dealing with this problem within its legislated role, which is primarily one of setting standards as conditions of limited financial support,technical assistance, and advocacy. I will talk more about these efforts later.

As to our knowledge about the actual extent or the exact nature of institutional child abuse and neglect in the United States, it is abysmally minimal. To a large degree this is so because, as I mentioned above, the administrative, regulatory and proprietarial systems which have charge of such institutions are generally within the control of the States. The problems that turn into the abuse of children in institutions are best known from articles, stories, and exposes in news articles,on TV, and from Ken Wooden's book Weeping in the Playtime of Others. We read and hear of specific instances of dehumanizing conditions, lack of staff, inadequate facilities, absence of basic resources, indifferent attitudes, and administrative inadequacies that often result in a child or children being victimized, sometimes irreparably harmed, or in rare cases, even killed. Yet we have only meager data on the nature, incidence and severity of such residential child abuse and neglect, and no definitive statistics. For example, the validated reports collected by the American Humane Association for 1977 included 81 reports from 26 states involving an employee of a residential institution.

From this limited information, and based on the specific instances that have come to our attention, we are led to suspect that we are only learning about a very small portion of the problem. From the individual occasions of known child maltreatment in institutions, we know that, at the very minimum, procedures to provide protective services to children who depend on care in these settings are as important as such procedures are for children at risk of maltreatment at the hands of their parents.

HEW ACTIVITIES TO PREVENT INSTITUTIONAL CHILD ABUSE AND NEGLECT

The Child Abuse, Prevention, and Treatment Act of 1974 which created the National Center on Child Abuse and Neglect gave the federal government responsibility primarily for the prevention and treatment of abuse within the family. The responsibility of the National Center extends to institutional abuse. Its role os one of technical assistance and active encouragement to the states in the areas of prevention, identification, and the remediation of child abuse and neglect in residential institutions.

In fulfilling its responsibilities towards institutionalized children, the Center has focussed on four primary areas:

- reporting, investigation, and correction procedures
- model state legislation
- co-sponsorship of a national conference on institutional abuse of children
- demonstation grants on investigation and correction of institutional abuse.

Let me describe each of these efforts and then turn to other activities ongoing within the Department.

REPORTING, INVESTIGATION, AND CORRECTIVE PROCEDURES

One requirement for eligbility for state grants is that the state must develop procedures, with the force of state law or administrative regulation, to handle the receipt of reports of known or suspected institutional child abuse and neglect, its investigation and correction. As a part of the Act and spelled out in Federal regulations which implement the Act, the state must provide for the reporting of known or suspected incidents of child abuse and neglect in such a way that the legally authorized investigative agency may not be made responsible for investigating itself where it also is responsible for running the residential program which is under investigation.

In Fiscal Year 1978, a total of 47 states[1] had attained full or conditional eligibility for state grants, and we expect that number to reach 50 during Fiscal Year 1979. To meet the eligibility requirements as they affect institutional child maltreatment, states have vested investigative authority in various agencies. For example, Vermont directs that all reports involving caregiving agencies administered by the Social and Rehabilitation Services (which is the mandated Child Protection Agency in that state) shall be directed to the Secretary of the Agency for Human Services. The Secretary then directs an outside investigation and makes recommendations.

MODEL STATE LEGISLATION

To assist states in developing their own child abuse and neglect legislation, the National Center developed a Draft Model Child Protection Act. This was widely distributed for comment to policymakers and professionals in the field. Although still in draft form, it has already been used as a blueprint for enacting legislative amendments by several states. This Act includes a section that specifically addresses institutional child maltreatment. That section incorporates requirements for: (1) desig-

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1/ P.L. 93-247 specifies that the term state includes the several states, the District of Columbia, Puerto Rico, the U. S. Virgin Islands, Guam, Samoa, the Commonwealth of the Northern Mariana Islands and the U. S. Trust Territories.

nation of an independent investigative agency; (2) an official agreement containing procedures for receiving reports, making investigations and taking remedial action; and (3) a means of incorporating information on the progress, findings and dispositions of investigations into the state's central child protection system. In addition, the Act provides for purchase of service agreements between a state's mandated child protection agency and another public or private agency to serve as the officially designated investigative authority in residential cases.

NATIONAL CONFERENCE ON INSTITUTIONAL ABUSE

The National Center on Child Abuse and Neglect co-sponsored, with its Region II Resource Center at Cornell University,a pioneering National Conference on the Institutional Maltreatment of Children in June of 1977. Attended by a multi-disciplinary/multi-agency group of 80, this conference focused on identifying the major issues and areas where change is needed, increasing public and professional concern, and on developing strategies to correct and prevent institutional child maltreatment. A recent report by the Center entitled Child Abuse and Neglect in Residential Institutions: Selected Readings on Prevention, Investigation and Correction, incorporated the report of the proceedings of the Conference along with other materials on the subject.

Major areas of concern identified by Conference participants include: size, inadequate staffing, isolation from community and family; need for public awareness; need for expanded regulation of residential institutions; need for appropriate alternatives and support services to reduce unnecessary institutionalization.

Recommendations that emerged from the Conference have been and will continue to be useful in shaping policy of the Center. Another result has been the development of specific standards addressing institutional abuse which were included in the Draft Federal Standards for Child Abuse and Neglect Prevention and Treatment Programs and Projects. These Draft Federal Standards were published and distributed for review and comment by the field in March, 1978, and are currently being used in program development, even in draft form. We've received more than 70 comments, overwhelmingly positive, which are currently being reviewed as we redraft the standards for final dissemination.

DEMONSTRATION GRANTS

In September, 1978, the National Center awarded four demonstration grants on the "Investigation and Correction of Child Abuse and Neglect in Residential Institutions." Eligibility for these grants was limited to state agencies with legal authority to make investigations and take corrective action. The grantees were chosen by a non-Federal peer review panel.

The grantees are the Utah Division of Family Services, the Massachusetts Office for Children, the District of Columbia Social Rehabilitation Administration, and the New Jersey Division of Youth and Family Services. Each received approximately $80,000 a year for a project period extending three years. These demonstration projects will develop procedures for making practical use of the goals embodied in child abuse legislation.

Since several of the projects will be testifying here this morning, we will simply provide you now with brief descriptions of these four projects:

- Utah's project plans to conduct a comprehensive computer search of the relevant professional literature; generate demographic,attitudinal, psychological, and socio-economic profiles of staff and residents of all types of residential institutions; employ "participant observers" for monitoring behavior and gathering observational data about the types of interactions between and among staff and residents; develop and implement treatment methods; establish multidisciplinary Correction Action Teams for each institution; and develop and validate a system for reporting known and suspected cases of institutional abuse to an independent investigative agency.

- Massachusetts' project is creating substate regional visitation-review committees and a statewide task force to address primary prevention; refining licensing and standard setting functions for the residential placement of children, and refining the mechanisms worked out with the State Department of Welfare for receiving reports and investigating and correcting individual cases.
- The District of Columbia's project is initiating a system for allowing residents in the institution to report maltreatment by signing their names to a form and depositing it directly into locked boxes which will be checked daily. These reports, together with staff-initiated "unusual incident reports." will begin an investigative and corrective process that will involve independent investigators, a review panel which will include residents and outside advocates and make recommendations to the Administrator of the Social Rehabilitation Administration. In addition, the project will provide Advanced Counseling Groups for staff to aid them in dealing with staff-child confrontations and problems of discipline.
- New Jersey's project is examining and testing three different approaches to advocacy and procedures, using internal, state administered, and private citizen advocacy systems of investigation. It will also make

a major effort at raising awareness of institutional employees of their responsibility to report known and suspected cases of child maltreatment.

These grants were awarded four months ago and the projects are still in their start-up phases, but they hold promise for serving as models for other states. As part of their dissemination and utilization requirements, the projects will be providing interim reports on the early findings of their work.

In addition to these National Center activities, there are a number of other HEW activities which relate to the prevention and correction of abuse and neglect of children in institutions.

Let me cite just a few, beginning with the HDS programs.

- o The President's Committee on Mental Retardation has just drafted a report on the prevention and treatment of child abuse and neglect in institutions for the mentally retarded. This report incorporates material contained in the Draft Federal Standards for Child Abuse and Neglect Prevention and Treatment Programs and Projects and has been considered by the Committee this past week. PCMR is now planning site visits to institutions in order to focus on accrediting policies, on methods of behavioral control, and on the use (or misuse) of medication. Findings from these visits and the draft report will form a basis for recommendations on how to reduce abuse in institutions for the mentally retarded.

- The Developmental Disabilities Program over the past eight years has provided funding for a contract which developed standards for residential facilities and for the development of training programs in the use of these standards. A training program utilizing these standards is provided by the contractor to institutions for a modest fee. More than 100 workshops in 35 States have been held since 1975.

- Since the fall of 1977, DDC has assisted states in creating Protection and Advocacy programs. Several states have used their own funds to supplement the federal funds and have created programs focussing specifically upon residential institutions. New Jersey, Illinois, and Michigan have developed programs of residential advocates who work with the state institutions. Delaware, Indiana, and New York are currently organizing their own institutional protection and advocacy systems.

- The Children's Bureau has supported the development and use of curricula for the training of residential child caregivers and foster parents.

- The Runaway Youth Program, administered by the Youth Development Bureau, provides services for young people who have run away from institutions as well as from their own homes. The program works to correct the conditions affecting the young people who come to the shelters it funds.

- The program to be developed as a result of the Adoption Opportunities Act you sponsored, Mr. Chairman, will assist in alleviating potential abuse of children in institutions by enabling permanent placements to be increased. The model act, the data gathering system, the adoption information exchange and the training and technical assistance activities will provide direction to state and local governments and agencies to aid them in increasing opportunities for adoption.

Under the Medicaid Program, several requirements have a bearing on child abuse detection and prevention:

- Institutions receiving Medicaid or Medicare payments for longterm care must have in place a "Patient Bill of Rights" which specifically provides that each patient shall be free from mental and physical abuse, and free from chemical and physical restraints, except under certain limited conditions.

- Institutions are also subject to medical and professional review requirements under which a team of health professional annually review each patient's care. In addition, each institution is reviewed annually to ensure that it meets certification standards. These reviews provide an opportunity to detect abuse of the patient.

In addition to these HEW activities, I believe the Department of Justice has worked toward deinsitutionalization or more appropriate institutional placement in a number of ways. I defer to Justice for specific comments on those efforts.

RECOMMENDATIONS FOR FUTURE ACTION

Mr. Chairman, this Administration has consistently encouraged each state to furnish services directed at the goals of (1) preventing or reducing inappropriate institutional care by providing for community--based care, home based care, or other forms of less intensive care; (2) securing referral or admission for institutional care when other forms of care are not appropriate; (3) providing services to individuals in institutions. This includes expenditures for administration (including planning and evaluation) and personnel training and retraining directly related to the provision of those services.

We are proposing several different ways to reduce the abuse and neglect of children in institutions. We will again be asking your assistance, Mr. Chairman, in enacting this year's Child Welfare Amendments, which as you know, are designed to improve the foster care and child welfare systems by requiring protections for the children in care such as case reviews and hearings on the status of their placements.. The proposal also stresses the need for permanent placement of children, either through services designed to return them to their families, or through a program of subsidized adoption for children with special needs.

Recognizing that licensing is a primary tool for assuring the protection of children as well as providing a floor of protection against hazards, and a basic level of quality of care below which it is illegal to operate, the Children's Bureau will continue to actively assist states in upgrading and strengthening their licensing programs through:

- o publication of materials such as Licensing - Interaction between the Licensing Agent and Service Providers
- o provision of technical assistance by Children's Bureau staff to individual states

- o inclusion of training for state licensing staff as a priority in awarding grants under section 426
- o development of licensing materials for state use including a model licensing law; guideline licensing requirements for child placing agencies, child care institutions, and foster family homes; and describing the key elements in an effective licensing operation.

In addition, as I mentioned earlier,we have developed a number of recommendation for the states since the legal authority and administrative structures for change are primarily at the state level. There is a strong federal responsibility for leadership, information dissemination, and advocacy which we have begun in order to better safeguard those children who live in residential institutions.

We welcome the opportunity to work with you and the Subcommittee, Mr. Chairman, in encouraging state and local agencies to make the changes needed.

Thank you. I will be happy to answer any questions you may have.

QUESTIONS SUBMITTED TO HEW BY SENATOR CRANSTON

Question. How much money is the Federal Government spending on keeping their children with their families and preventing inappropriate foster care as compared to the amount of money the Federal Government expends on keeping children in foster care? On April 4, 1977, when I asked you said you had no data and could give only examples of HEW-funded activities. Have you made any progress in finding out the answer?

Answer. We do not have good data on totals of federal funds being spent on keeping children with their families and preventing inappropriate foster care, as compared to the amount of money the federal government spends on keeping children in foster care.

We are able to provide, however, estimated fiscal year 1977 combined uses of the HUDS Title IV–B Child Welfare Services funds (combined Federal-State-local) by five service categories including protective services and foster care as follows:

Adoption	$24, 488, 851
Day care	36, 426, 137
Foster care	555, 879, 275
Protective services	41, 773, 093
Other	37, 294, 796
Total	695, 862, 152

Of this total, $56.5 million represents Federal IV–B funds. Information currently provided by the States does not precisely isolate how the Federal dollars are spent. Obtaining this information is a priority effort by fiscal year 1980.

In addition, estimated use of title XX funds for fiscal year 1977 by the same five services as listed above are:

Adoption	$22, 527, 000
Day care	606, 058, 000
Foster care	250, 438, 000
Child protective services	203, 518, 000
Other	19, 788, 000
Total	1, 102, 329, 000

Finally, $4,732,000 Child Abuse and Neglect funds will be going out as State grants in fiscal year 1979 to be used for child abuse protective services aimed at prevention and treatment of child abuse and neglect as provided under that Act.

Total Foster Care Payments under IV–A, the AFDC foster care programs, were $351.2 million of which the Federal Share was $183.9 million.

Question. What will the $5 million for Adoption Opportunities generally be spent for? Give a detailed breakdown for the record.

Answer. 1. *Creation of an organizational focus in adoptions.*—Responsibility for the program has been delegated to the Commissioner for Children, Youth and Families, who in turn has placed the administrative responsibility in the Children's Bureau. In addition, the Commissioners for the Administration for Children, Youth and Families, Administrtaion for Public Services and Office of Family Assistance (in the Social Security Administration) have established a formal intra-departmental committee on adoption and foster care to enable these offices which provide services to children and families to exchange information, identify significant problems, and propose joint recommendations. This Committee is already working on a number of issues, and is establishing a counterpart group in each federal regional office.

This effort will be carried out with existing funds.

2. *Establishment of a national adoption information Exchange System.*—We plan to carry out the following two tasks:

a. Design an exchange network at the State, regional and national level which places primary emphasis on the responsibility and capacity of States to place their own children, and which develops a rationale and system for identifying those children who cannot reasonably be expected to be placed within their own States and communities.

b. Develop regional and national support systems which (1) provide technical assistance to State and local exchanges and help them develop a network of communication with each other and (2) identify and work with other regions and States in the placement of children who are unable to be placed within their States.

To accomplish these tasks we will award a national technical assistance contract to a qualified organization, along with ten demonstration, regional Adoption Resource Centers (see description below), each of which will have at least one full time person working on these tasks within the region. The national technical assistance contract, in addition to designing the system and providing technical assistance, will operate a very small demonstration matching service at the national level for those multi-problemed children who require the widest possible geographic scope in their search for a permanent home.

We do not propose to fund or operate adoption exchanges at the State or regional levels. Rather we see our regional role as information sharing, technical assistance, and coordination by means of a staff person located in each of the proposed Adoption Resource Centers (see below).

We are budgeting $500,000 to fund the national technical assistance contract.

3. *Development of an education and training program on adoption.*—We propose several broad based national projects to implement this requirement:

a. The establishment of ten demonstration regional resource centers on adoption. These centers will be the principal network for regional and central office staff to disseminate information, provide training and technical assistance, develop improved legislative and legal procedures in individual States and provide assistance to local parent groups. As the adoption information exchange system develops, the resource centers will have the responsibility for developing the system at the regional level.

b. The development of an in-service training curriculum including audio visual materials on the adoption of children with special needs, for use by State and local, public and voluntary agencies.

c. The development and dissemination of a series of bilingual television spots and radio announcements supporting the recruitment of adoptive and foster parents for children with special needs.

d. Demonstration grants to national adoptive parents groups working on behalf of children with special needs to enable them to advocate for the needs of waiting children, develop support systems for adoptive families, and address special problems of adoptive families working with special needs children. In addition, each regional adoption resource center will make very small grants to local parent groups to accomplish these objectives at the local level.)

e. A grant to strength and improve the operation of the Interstate Compact for the Placement of Children.

We are budgeting $3,850,000 to fund these projects.

4. *Establishment and operation of a national adoption and foster care data gathering and analysis system.*—A concept paper has now been completed with the assistance of several State representatives that will provide the direction for establishing and operating a national adoption and foster care data gathering and analysis system. It contains the rationale and approach that will be used in constructing the necessary data system for adoption and foster care services to children and their families and for analysis and dissemination of national statistics. The concept paper has been reviewed by the Social Services Committee of the American Public Welfare Association. We will begin this effort in fiscal year 1979: We are preparing a request for proposals (RPD) for the development and implementation of this system.

We foresee three Phases leading to full operation: Phase I—Technical Development; Phase II—Field Test; and Phase III—Implementation. We expect that the development work will take 15 months; test and pilot implementation 12 months; and 18 months for full implementation in all States and jurisdictions.

We are budgeting $600,000 to fund this effort.

5. *Model adoption legislation and procedures advisory panel expenses.*—In addition, by means of a grant to the Child Welfare League of America, a study of independent adoptions has just been completed that we believe substantially meets the requirements in Section 204 of Public Law 95–266. The book, Adoptions Without Agencies, gives the detailed results of the study.

Timetable.—All of these activities will be funded no later than September 30, 1979.

Senator CRANSTON. We are going to take a very brief break and then proceed with the next witness.

[Short recess.]

Senator CRANSTON. The hearing will now reconvene.

Our next witness is Senator Backman, Massachusetts Senate. The senator's committee on human services has been holding hearings on the problem of abuse in institutions in his State.

I deeply appreciate his willingness to join us today and taking the time from his own busy schedule to share with us his views on this problem.

Senator, we welcome you.

STATEMENT BY SENATOR JACK H. BACKMAN, CHAIRMAN, COMMITTEE ON HUMAN RESOURCES, MASSACHUSETTS SENATE, COMMONWEALTH OF MASSACHUSETTS

Senator BACKMAN. Thank you, Senator Cranston. Knowing the frustrations, the bureaucracy, and the redtape in just one State, the Commonwealth of Massachusetts, I do envy you your present role in trying to determine what to do about abuse in State institutions all over the country.

I wish you well.

Senator CRANSTON. Thank you very much.

Senator BACKMAN. Throughout the Nation, Massachusetts, is sometimes viewed as a model State with a progressive approach to the treatment of youthful offenders. Indeed, reforms instituted in the early 1970's by the commissioner of the Massachusetts Department of Youth Service, Jerome Miller, closed down almost all of our "kid" jails, the reform schools, forestry camps, and training schools which housed most of the youth in the Commonwealth's custody.

I believe Dr. Miller is also going to be here today. Just as an aside, I might mention when he first came to Massachusetts, I met him outside my door on the stairway. I still recall that the newspapers said something about his plans to deinstitutionalize Massachusetts secured facilities for children. I said, "Jerry, I do not believe you. How long is it going to take?" He said, "Within 4 years."

Well, he did it in 4 years, and he was in another State in 4½ years. What he had to go through would be a story in itself.

In the place of the institutions we closed down, there was to be created a network of community-based care relying on counselling, foster homes, and residential group treatment programs.

As a result of Miller's actions, only 11 percent of the young people in the custody of Massachusetts Department of Youth Services, are now held in "secure" settings. Compared with the U.S. average of over 80 percent, this statistics leads most casual observers to conclude that Massachusetts must have one of the most humane systems of juvenile corrections in the entire country.

Unfortunately, this figure is far from the entire story. In fact, fear, intimidation, violence, abuse, and neglect remain rampant in the Massachusetts Department of Youth Services, just as they are all over this country.

At the Worcester Secure Treatment Unit, for example, conditions drove three boys to attempt suicide in one 3 month period last year. One, regrettably, was successful. Until investigations by my office and an independent task force on institutional abuse forced DVS to totally renovate the facility, the Worcester unit was little more than a jail with barbed wire, cyclone fences, kleig lights, concrete block walls, and cramped, dingy cells which failed to meet the State's minimum health code.

I have a photograph of the facility, and you can see what it looks like, even from a distance. Terribly enough, the windows in this institution were painted green from the outside, theoretically for the privacy of the children. As a result the children could not even look out of the few windows of the institution. Some residents were locked in solitary confinement for as much as a month at a time. Treatment programs and counseling were virtually nonexistent.

The Massachusetts Office for Children, the State agency responsible for licensing and monitoring, took no action against Worcester until after the independent investigations became public. Even then, OFC's first reaction was to fire the two employees who assisted the citizen groups making the inspection. A few weeks ago one of those employees collected 6 months' back pay as a result of the court suit he instituted.

The OFC delay is hardly surprising: Of 306 groups, shelter, and foster care programs housing children in the custody of the commonwealth, only slightly more than half, 162, have up to date regular OFC licenses, and 36 have provisional certificates signifying that a full investigation has not yet been completed although basic legal standards appear to be met. About 100 have no valid current licenses whatsoever.

The inability of even a so-called progressive State like Massachusetts to monitor its own programs has forced advocates to turn to the courts to protect DYS detainees. Our Roslindale Secure Detention Unit, for example, is run under comprehensive provisions of a Federal district court consent decree—negotiated by the Commonwealth in 1976 to settle a suit alleging cruel, unusual, dehumanizing, hazardous, and unconstitutional conditions at the facility. Over 75 provisions were imposed governing virtually every aspect of intake procedures, visits, maintenance of records, medical treatment, disciplinary practices, and sanitation.

Yet in spite of the court order, this summer several staff members at Roslindale charged into the recreation room brandishing baseball bats, a leather strap, and handcuffs linked onto a towel in reaction to a report that one boy was picking at a heavily barred second-story window with a piece of aluminum from a Ping-pong table net support. The guards swung their weapons wildly, three boys were struck, all were stripped naked and 13 were summarily given solitary room confinement for 24 to 48 hours. A subsequent investigation revealed violations of more than a dozen specific consent decree provisions in the handling of this single incident.

I might add that just 2 days prior to this incident, the attorneys for the Department and the attorneys for the people bringing the lawsuit were in Federal Court and reporting to the judge that implementation of the consent decree appeared to be proceeding smoothy.

This litany could go on for hours. Since your time is short, I will leave with you copies of the testimony on instiutional violence in the Massachusetts Department of Youth Services delivered before the Committee on Human Services 2 months ago.

The situation in Massachusetts is so bad that before our committee, the Chief Justice of our district court system stated that he always tries to divert youth offenders away from DYS because, in his words: "The system fails and will continue to fail."

If Massachusetts is the best State in the Nation, what does the worst look like?

It is important to stop here and note that our bitter experience does not, however, prove that reforms cannot succeed. Quite the contrary, our problem is that the reforms in Massachusetts never went far enough. Jerry Miller's vision was only half implemented. He did shut down most of the outmoded institutions, but he was forced to leave Massachusetts before he could set up his proposed system of counselling, foster homes, and residential group treatment programs and train the staff needed to make the new system work.

The result of these half-way reforms is that the Massachusetts juvenile correction system is caught in conflicts between new and old ideas. The institutions that survive remain human warehouses and hotbeds of child abuse. For children in the custody of the Commonwealth, whether in institutions or community-based facilities, there is still insufficient oversight, monitoring and evaluation to assure effective treatment in a humane environment.

The recent hearings of our Human Services Committee on institutional abuse in the department of youth services indicated that some remedies to these continuing problems are within the control of our State. During the coming year, we shall be pressing to increase funding for licensing and monitoring of facilities by the office for children, to upgrade the staff in our remaining institutions, and to provide an independent ombudsman to investigate reports of violence to youth in the Commonwealth's care.

I will also be appearing in Federal district court along with legal advocates of children in the secure institutions arguing to expand the consent decree already governing discipline, physical force, seclusion and other policies at the Roslindale Secure Detention Unit to cover all other secure facilities. We also will ask the court to order an effective monitoring process to ensure compliance and a guarantee of legal counsel so detainees may secure the rights stipulated in the consent decree.

Yet, even if all these proposals are adopted, I am well aware that we will not end the problem of abuse of young people in the Commonwealth's custody. So long as we rely on institutions instead of solving the underlying problems that cause delinquency, inmates will be vulnerable to inhumane conditions and inadequate programs.

Long-term solutions involve attacking the root cause of crime and violence. A recent Ford Foundation-sponsored study of inmates at the Brockton Secure Detention Center, for example, found a "high proportion of significant illnesses in the delinquent group which were either not diagnosed, misdiagnosed or properly diagnosed without even minimal followup care." Dr. Peter Wolf completed the study just a few months ago and, as he testified before our committee, over 50 percent of the youngsters who came into this secure detention facility had severe health problems which were unattended.

The study also concludes that 70 to 85 percent of the youngsters were in need of special education, in need of special assistance to cope with society. What is even more damning is the discovery that the institution had no facility to attend to these problems.

Also uncovered was a wide range of behavioral disorders, including hyperkinesis, specific learning, and visual problems. Nearly three-quarters of the juveniles tested could not read at the standard for their age level.

Perhaps adequate treatment and education of these youngsters at an early age would have kept them out of DYS in the first place. After all, the best way to reduce institutional abuse is by reducing the number of people in institutions.

Though it can do nothing about these basic problems, a Federal role like that outlined in S. 10, could contribute to reducing abuse of the young people who do end up in institutions. Granting the U.S. Attorney General legal standing to protect constitutional and Federal rights will afford detainees another channel for legal remedy. It would also provide a mechanism to gather accurate information on the extent and nature of institutional abuse throughout the country. Most importantly, the expanded powers of the Attorney General would bring strong pressures of accountability to bear on local officials who have the primary responsibility for the conditions in State institutions.

On that point I would like to mention something that perhaps was not mentioned. We have a very fine attorney general in Massachusetts. He has done some great work protecting the constitutional rights of minorities, children, prisoners, and others. However, in the usual course of events the prime role of the attorney general in Massachusetts and elsewhere is to defend State government. When we talk about lawsuits and consent decrees, we must begin with an adversary procedings in which the Attorney General is mandated to protect those people who are causing the abuse of children. That is another reason why we need the input of the Federal Government.

Certainly, Federal intervention is far from the total solution. But it can help make institutions a bit more humane and that much more likely that the young people who are incarcerated will become productive adult members of our society. That must remain our ultimate goal.

Senator **Cranston**. Thank you very much for your very helpful testimony.

In regard to that incident at Worcester and the impulse to retaliate against employees who revealed improper circumstances, that would seem to indicate the need for whistle-blower protection.

Senator **Backman**. It sure does.

Senator **Cranston**. Do you have any such protection or has any been considered in Massachusetts?

Senator **Backman**. The original organization of the office of children included advocacy groups in all the regions of Massachusetts. Because of the national fiscal crunch, funding was taken away, and local advocacy groups that had developed were deprived of their office space and staff. I think the model of the Massachusetts Office for Children, if fully implemented, would have been fine. But these concepts are never fully implemented. As soon as citizens' groups become too strong, there is an attempt to take away some of their power.

Senator **Cranston**. The key matter is trying to protect people inside from employees who may know about abuses that are occurring but who feel there will be reprisal of one sort or another. Under the Federal Child Abuse Prevention and Treatment Act, in order for a State to qualify for assistance, that State is required to have in effect a child abuse and neglect law which protects persons reporting incidents of child abuse from prosecution under any State or local law as a result of the reporting. Do you believe that it would be beneficial to extend this provision to protect individuals such as those two employees, of reprisals, such as firing?

Senator **Backman.** I certainly do. It will not completely prevent harassment, because there are many reasons that can be fabricated by the bureaucracy. After an incident takes place, we suddenly find there are 10 reasons to fire someone. In the instance I mentioned at Worcester, I was called at my home by the director of the Office of Children who stated she had just fired these people because they had contacted my office. I was amazed. I do not usually have social calls from that particular director. And it turned out that I had never even met one of the young people who were fired and had spoken to the other one for only a very brief period.

This kind of thing does not happen only in Massachusetts.

Senator **Cranston.** We, obviously, should protect people against that.

Senator **Backman.** In the incident at the Roslindale Unit involving baseball bats, a young DYS employee did report the incident to the assistant commissioner of youth services. But the information was never conveyed to the Commission, and the next day the young man's clearance to go into the institution was taken away, and 1 month later he was fired. After he was fired, the staff member came to my office. The resulting investigation disclosed that his statements were actually understated.

Senator **Cranston.** Thank you very much.

Senator **Backman.** Thank you, I also am submitting the statements made before our Committee on Human Services during our own hearings on institutional violence.

Senator **Cranston.** Certainly.

[Editor's note: Due to the voluminous nature of the hearing material mentioned and in the interest of economy, the same was retained in the files of the subcommittee.]

[The prepared statement of Senator Backman follows:]

COMMONWEALTH OF MASSACHUSETTS
MASSACHUSETTS SENATE
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CHAIRMAN
COMMITTEE ON HUMAN SERVICES
CHAIRMAN
SPECIAL COMMISSION ON EMPLOYMENT

February 22, 1979

Sen. Alan Cranston

Dear Alan –

I appreciated the opportunity to appear before your Committee.

One thing is clear from the testimony – in Washington + Massachusetts:

– That we have utterly failed in our institutions – whether it be for children, the mentally ill, the retarded, the elderly – or those convicted.

Our society has been warehousing human beings in unfit and violent settings which dehumanize not only the clients – but the keepers.

My best regards – and please do not hesitate to call upon me if I can be of help —

Sincerely

Jack Backman

Senator CRANSTON. We are going to proceed with our first panel consisting of Kenneth Wooden, National Coalition for Children's Justice, Princeton, N.J.; Mary Lee Allen, Children's Defense Fund, from Washington, D.C.; and Jerome Miller, National Center for Action for Institutions and Alternatives, National Youth Workers Alliance, Washington, D.C.

Please proceed.

STATEMENT BY KENNETH WOODEN, NATIONAL COALITION FOR CHILDREN'S JUSTICE, PRINCETON, N.J.; MARY LEE ALLEN, CHILDREN'S DEFENSE FUND, WASHINGTON, D.C.; AND JEROME MILLER, NATIONAL CENTER FOR ACTION FOR INSTITUTIONS AND ALTERNATIVES, NATIONAL YOUTH WORKERS ALLIANCE, WASHINGTON, D.C.

Mr. WOODEN. My name is Kenneth Wooden. I am with the National Coalition for Children's Justice.

On December 20 of last year, I gave 20 major newspapers documentation that showed at the time of the mass murders in Guyana, the late Rev. Jim Jones was receiving from the Federal Government and the State of California, $137,000 annually for the operation of Happy Acres, an institution for 13 young retarded persons. This lease (see app. "A") substantiates that all profits from Happy Acres were to be remitted to the People's Temple.

Also, while Jones operated in California, his numerous "child care homes" for foster children—public wards of the State—netted hundreds of thousands of dollars. I urge you, Senator Cranston and the Congress, to vigorously pursue that money and those foster children who were placed in the hands of Jim Jones, for the following reasons——

Senator CRANSTON. I assure you we are already doing so through an investigation that we have asked the General Accounting Office, the investigative arm of Congress, to undertake.

Mr. WOODEN. I would like to make a few points on that.

The Governor of California is not aware that Reverend Jones' wife worked for the State of California for Santa Rosa Health Department. I urge you to urge GAO to secure Mrs. Jones' work records and her referrals to the People's Temple. The same with other employees, child counselors, probation officers, who were members of People's Temple and were referring children. I urge you to subpoena their work records and information. It is going to be very difficult to trace all the children because Guyana did not require fingerprinting of anyone under 16 that entered that country.

As dramatic as it is, I do not want to dwell on Reverend Jones' successful handle on children and Federal-State dollars because People's Temple was merely a minute tip of a massive iceberg; that is, the mushrooming business of amassing quick fortunes by gathering children in the name of child care. If this iceberg remains unchecked and uncharted, it can very well sink the essential protective services that the American people, through the Congress, have generously provided its young.

On January 4, you opened these hearings in San Francisco, and speaking about the 800,000 children locked in the child care system, you stated: "I believe that the human rights of many American children are being violated in institutions where they are subject to cruel and inhumane treatment."

Permit me, Senator Cranston, to document that statement, using four institutions involving approximately 500 young people. They reflect conditions for many of the 2 million other youths that come under the guardianship of the State.

During the last 7 years, as I have traveled all across the United States, I have witnessed countless children in solitary confinement without clothes, heat, toilets or hope. Children who are beaten physically and psychologically. Children who are sexually assaulted by both staff and older children. Children who finally lost hope and committed suicide with light bulbs, electrical wiring, bed bars, door knobs and rat poison. Conditions in some facilities are so deplorable that they defy the imagination and therefore are dismissed by many as "sensational journalism" or "pure theater." One thing is certain: As long as we, through ignorance or educated greed, deny these conditions exist, the cruel and inhuman treatment you mentioned, Senator, will continue year after year, decade after decade, generation after generation.

I would like to present to this committee three profitmaking corporations that I have personally visited and are, in my opinion, abusing children and the taxpayers without fear of Federal Government scrutiny of their treatment or financial operations. I will gladly provide supportive information and documentation to your committee or any investigative arm of the Congress. The corporations are: One, New Horizons Youth Ministries, Caribe-Vista program for American children; Dominican Republic; two, Provo Canyon School, Provo, Utah; three, Clinicare Corp., Eau Claire Academy, Eau Claire, Syalusing Academy, Prarie du Chien, Wis. and Winona Heights Academy, Winona, Minn.

The Carib-Vista New Horizons program, located in the Dominican Republic, is the creation of Gordon Blossom, a retired clergyman living in Grand Rapids, Mich. Although the State of Michigan has refused to grant Blossom a license and the State's attorney's office is currently trying to close down his operation, he is sending American children out of the country for such crimes as running away, school truancy "and being out of control."

Though this material is somewhat dated, I visited Carib-Vista in the summer of 1976—I believe Jonestown has taught us what can happen to Americans living abroad without the knowledge or concern of their Government. And since I reported the deplorable health and living conditions to the State Department and the Congress in 1977, and since Mr. Blossom is still in business, I can only assume the place needs looking into.

I would like to share with you my 1976 observations of a facility that is currently charging taxpayers in Evansville, Ind., $8,360 a year per child. Carib-Vista was totally unsupervised by any outside American. Blossom's daughter and son-in-law ran all three group homes. Staff was paid $100 per month and a promise of a better job elsewhere, because of their experience gained at Crib-Vista. A key point is parents were not permitted to visit for the first 4 months and mail was censored at all times. I submit to you parents cannot visit their children so Gordon Blossom can brainwash their children on his religious programs. If a child had any dental problems, local unqualified students would pull a tooth for a quarter. Education was nothing more than correspondence courses.

Forms of discipline were demonstrated to me as I was talking to about 10 kids. One young girl who had her head shaved was taunted by a staff member to tell me why she was bald. As she stood in silent shame, he harrassed her about her weakness of the flesh—she ran away for the weekend and mingled with a local Dominican male.

The director of religion freely admitted that the children were beaten with a stick on the rump "hard enough to make them fear it." Three days of solitary confinement was given before the beatings.

Can you imagine forcing a child 16 years old to explain to strange man, myself, why her head was shaven and how the director of religion required that girl to talk about her sexual life on weekends when she would slip out of the facility and how she was beaten with a stick and how she was placed in solitary confinement.

The young girl who was degraded, so degraded by these people was there without any Government scrutiny on the part of the United States.

Gordon Blossom is making a lot of money, figuring the amount of kids that are down there, figuring what he is paying, the cost is paying for his program—what appears to be a glorified babysitting outfit, could have made Gordon Blossom a millionaire in 4 years. His program is now 8 years old. I believe if the State of Michigan has refused to allow New Horizons Youth Ministries to operate at home, certainly someone from the State Department with a background in public health, should visit and evaluate the operation in the Dominican Republic.

In Utah, the Provo Canyon School is flourishing, with 110 boys at $15,600 per child per year.

Senator CRANSTON. What is the figure?

Mr. WOODEN. $15,600. They are grossing $1.7 million. The school used to be in Mapleton, Utah, and was known as the Oak Hill School. But long before human rights became fashionable on a global scale, citizens of Mapleton tired of finding children who had escaped from the school with iron manacles around their ankles. The Oak Hills School was told to relocate and they did.

Ex-marines at Provo Canyon School practice orientation techniques that would terrify any adult. According to parents and children, some kids are introduced to the school in this manner: Late at night—with the parents' knowledge—two employees from the school come to the sleeping boy's room, violently awaken him, wrap him in his own bed sheets and carry him off to a waiting van where he is thorazined and taken to the school. There, during an initial 1- to 3-month period, he is kept in secure lockup, aimed at breaking the boy's spirit so he will conform to strict institutional rules.

There is a lawsuit which has just been introduced concerning Provo Canyon by a lawyer named Kathryn Collard.

Following are documented facts that came to light during *Milonas v. Williams*—a class action lawsuit by Kathryn Collard against Provo Canyon School:

(1) The defendant, coowner and administrative director of Provo Canyon School, did not complete high school and has no formal training in child development or child psychology.

(2) "Counselors" hired to monitor student behavior are required to be 6′2″ tall and weigh close to 200 pounds. These same counselors "administer thorazine, stelazine and other control drugs to the children without medical supervision."

These are the people that supervise the children.

The kids are placed in a room called the Pee Room, solitary confinement, 3 feet by 3 feet, so it is impossible to lie down in that room. There are no toilets.

The kids are forced to go to the bathroom on the floor and stay within that room.

I was told I only have a few minutes and I must summarize, but I respectfully ask for a few more minutes because I would like to talk about the State of Wisconsin and the State of Minnesota.

Senator CRANSTON. Go ahead and take your time. You are giving us some very important testimony.

Mr. WOODEN. They have a punishment called stand in, where a kid receives 40 hours of standing. If he falls asleep, one of the counsellors will squirt him with a watergun to keep him awake.

This is grossing $1.7 million a year. Sixty percent of the kids come from out of State, 19 kids from Alaska, and nobody is supervising that place. The school is part of the interstate compact. It is unlicensed, and it is a pathetic creation of Federal moneys going into that school with HEW money, handicap money, learning disability money, and things of that nature. But let me move on to Wisconsin and Minnesota.

There is a place called Clinicare, Inc. It was started by a man named George Dreske. He has three facilities.

The two that I would like to talk about are Eau Claire Academy and Winona Heights in Winona, Minn.

The tuition at Eau Claire is $2,317 per child per month. The conditions are deplorable. George Dreske is a convicted felon. He was bribing a State senator on the day the legislature was voting an increase in rates.

His institution has the highest rates in the State of Minnesota.

Let me run through some of the things that I discovered at Eau Claire. The staff is grossly underpaid. Until May 1978, there were people with college degrees receiving $2.75 an hour. Teachers with master's degrees were receiving $3,000 less than the public school officials.

Their psychiatrist is part time and, according to staff, comes in one afternoon a week and stays mainly on "Unit II," the secure floor for children who break institutional rules.

By using large quantities of behavioral drugs, less staff is needed. The local drugstore, Lelman Drugs, reported that the school makes drug purchases averaging about $1,200 to $1,500 per month, "higher in the wintertime probably because the kids are confined to the building."

Good behavior is rewarded by going to the local public school. At the time of this writing—January 12—Eau Claire Academy had five children enrolled at the local school. Over a 3-year period, more than 100 academy children have attended public school free, as residents of the city.

According to the Eau Claire Academy brochure, a major cornerstone of their program is a "highly developed physical and recreational education program." But the local district attorney says that program consists of taking the kids to the local YMCA.

Profitmaking facilities, like Eau Claire, pay such low wages that they, many times, attract a segment of society that is unfit to work with children. And for the sake of keeping costs down, they forgo the formality of screening personnel. Eau Claire Academy has on several occasions fired personnel for supplying street drugs to the children. Recently, they quietly dismissed a staff person who allegedly abused a young girl sexually. This, I sadly find, is common in institutions across the country. However, few perpetrators are turned over to the police because the owners and administrators fear it will damage their image and threaten future placement of kids. They are permitted to move on to the next institution, the next child, the next experience behind locked doors.

My visit to Eau Claire Academy left me with three disturbing observations: First, it was dirt—not recent dirt but accumulated filth. Second, the youths had nothing to do but sit around in cigarette smoke and watch endless TV. They wanted to do something meaningful. Lastly, I have never witnessed so many kids obviously under heavy drug sedation. These kids were walking zombies.

One boy was getting 50 milligrams of Mellaril three times a day. Another was getting three milligrams of Haldo four times a day while a third boy was getting five milligrams of Prolixin five times a day.

I could not help being touched by the human appeal of those young people whose minds were clouded, whose eyes were dazed and who, though embarrassed because they could not control their salivary glands, still tried desperately to communicate their plight, their need for help. Their hands, I feel, were not extended just to me personally, but beyond me—to you, to this committee, and to all caring people.

Winona Heights Academy has 42 children, each worth $22,584 per year. The man who built this small but prosperous million-dollar empire is George Dreske, a keen businessman and former owner and board member of Clinicare until his criminal conviction for bribing a State representative on the day the legislature voted to increase rates, for private facilities.

Richard Navarre said he was hired by Dreske with a promised budget of $120,000 to implement his educational ideas. But, according to Navarre, Mr. Dreske implemented his own educational program by going to auctions and buying old tools to impress the Minnesota licensing inspector, who was big on woodwork shops.

Another former employee, Bill Ebert, told me that his responsibilities were to supervise the "Penthouse," the interim room-between classroom and quiet room—for disciplinary problems. Kids who acted up in the Penthouse were placed in a broom closet—3½ by 10 feet with no toilet, no food, no mattress. Just a hard cold marble floor where children coped with the insanity of solitary confinement.

Bill Ebert told me that children are placed in solitary confinement at Winona Heights Academy and screamed and kicked and because there is no toilet in that institution, the human waste is on the floor, and when there is a day or two or three that goes by, they smear that on the walls and windows in total frustration and anger.

The man is grossing roughly $1 million from Winona Heights, and there is no one checking into that.

I went to the public health department and I told them in Milwaukee that I would like to place my nephew there if I could afford it but I could not afford $27,000. What would be my fair share? I told them I make between $40,000 and $50,000 a year, and they told me that I would have to pay the maximum rate, which was $4 a day under title XIX. So that for four bucks a day, could place a child in an institution and the Federal Government pays 60 percent, and the State 40, and the people that are in business and making money are having a ball.

Let me show you at this point two charts I put together to illustrate the amount of money that can be made in child care in America, and then I will end my testimony.

This is Clinicare, Inc. [indicated], and the information is current as of January 12 of this year.

Eau Claire Academy, 22 kids, based upon the rates, $2,300 per month, and they will gross $2,750,000.

Winona Heights has 42 children, based upon their current rates, $948,000.

The third institution has 64 children and they are getting $1.4 million.

So. George Dreske's little empire called Clinicare, Inc., can gross $5,165,000, and their child care, Senator, would give Mr. Carter some information to talk about human rights in America.

Here is another chart I would like to show you: My oldest daughter has applied to some colleges—her first choice is Yale—and my wife and I must come to grips with the burden of financing this education. Room and board at Yale is $7,500 yearly. If my daughter was a runaway, however, and was placed by the welfare department at Eau Claire Academy, it would cost $27,804.

Amherst College is $6,500.

Winona Heights is $22,500.

Swathmore College, $6,500.

Provo Canyon School, $15,600.

University of Vermont, $3,500. This is interesting because its estimate includes room, board, clothes, travel, and unlike the Dominican Republic, the parents can visit their children. Yet, there is a difference of close to $5,000.

Senator **Cranston**. How do they explain figures like $27,804 at Eau Claire?

Mr. **Wooden**. They explain it by writing fancy brochures and a lot of rhetoric about treatment. But from my experience and in my testimony I make some recommendations for financial accountability. They simply "BS" their way through, proposals and Federal guidelines.

I have never gone to an institution where they have had a full-time psychiatrist. It is always a part-time psychiatrist. Rarely, if ever, do they have a nurse at night.

What they were paying their staff out there was below minimum wage in May of 1978. The food is cheap. The recreational program consists of either the YMCA or local playgrounds, football fields or recreational areas. If you keep the cost down in capital and program and salaries, you can make large profits.

I think the burden should be on GAO to find out how they can get such high tuitions, $27,000 per year.

In closing, I would like to make some recommendations.

Senator CRANSTON. Cover the Sacramento, Calif. incident.

Mr. WOODEN. Another facility which is doing rather well is a not-for-profit corporation called the Sacramento Children's Home in Sacramento, Calif. In fiscal year 1977–78, their gross revenue from all sources totalled $3,655,836. The previous year they reportedly grossed $2,144,592.

Licensed for a 94–child capacity, Sacramento Children's Home is paid between $1,340 and $1,630 per month per child. Over a dozen reports from field visits and letters from licensing workers between 1976–1978 cited filth, fire law violations, lack of staff supervision, et cetera. Education not supplied by the local public schools is taught by cassettes and teachers that are dissatisfied with the program.

Again, they have dumped a lot of kids in the local school system at the expense of the taxpayers. Though their program is lacking, to say the least, their ability over the years to make monetary appeals is impressive.

I will give to you, Senator, a copy of their stock portfolio. It is impressive to see how many shares of IBM, A.T. & T., banks and other corporations they are squirreling the money away like a number of nonprofit corporations building up a stock portfolio.

It has been my experience that you always have abuse if money is unchecked.

I think the key to protecting children is total and tight financial accountability.

A few recommendations on this point.

I think it is imperative for the Congress to require all Federal programs to be audited and that audit made public.

Second, tax exempt, nonprofit organizations should be required to file a copy of IRS form 990—financial profile—with their respective States so that it is available to the public without long and costly delays.

Publicly owned, for-profit corporations should be required to file a copy of Security Exchange Commission form 10–K—financial profile—with their respective States for public availability.

Private for-profit organizations who obtain Federal grants and funds should be required to file a similar form at both the Federal and State levels of government.

Reports should be required on endowments to non-profit organizations—and others—and those reports be made available to the public.

Owners, major stock holders and directors of child care institutions and child advocacy organizations, as well as lobbies for the child care industry should be required to submit a full financial disclosure of their personal assets.

Real estate investments made with tax dollars should be monitored and returned, if legally possible, to public holdings.

There is need for a complete review of all Federal moneys to ascertain whether they foster an incentive for both parents and businessmen to abuse what are basically important and necessary programs in the health area.

Make Federal money available for city and regional audits of extensive and expensive residential foster care programs.

An audit done in New York City on 52 private voluntary agencies was devastating. That audit, or a similar audit, should be made in large cities like Chicago, Los Angeles and other areas where profit and nonprofit corporations have a lot of kids and a lot of public needs.

On April 4, 1973, I testified to the Subcommittee on Labor and Public Welfare chaired by Senator Thomas Eagleton. I ended my testimony with the following paragraphs:

In closing I want to leave you with one thought. In all my travels through youth correctional facilities, the most depressing areas to visit are those used for solitary confinement. Here you find the young, alone and lying in the fetal position. They are surrounded by the bitter obscenities and lonely names written on the walls by those who previously spent time in the same isolation cells.

Here on the walls names, dates and their poetry of obscenities silently voice separate and collective rage against the darkness of our night.

But of all the obscenities, the most powerful, the most glaring, the most deeply etched in the walls of the bricks and stones, the most deeply carved in the wood and scraped on the metal is that four letter word we all know and use ourselves from time to time. It is spelled H-E-L-P.

It is the worst obscenity because we as a people and a Nation permit it to go unanswered while the dreams of those children, generation after generation perish in the dust of their youth.

Very little has changed on that point, except that the entrepreneurs are making a lot more money these days. I don't believe that either the vast profits or the conditions are part of the President's inflationary guidelines or the rhetoric of his worldwide campaign for human rights.

Senator Cranston, I salute you for holding these hearings. Few political leaders care enough about children to look into it.

Thank you for the opportunity.

Senator **Cranston**. Thank you very much for very forceful and effective testimony. It has been a great benefit to us and adds a shocking litany of abuses to what we have already been hearing.

What is the reason for the Dominican Republic location? Is that to get away from the minimum of inspection?

Mr. **Wooden**. Because the State of Michigan would not grant him a license.

Senator **Cranston**. Are conditions worse down there than they are in the United States?

Mr. WOODEN. Extremely primitive. When I was down there they did not have running water. One of the group homes was situated in a village where poverty was incredible. Human waste, animals. Kids did nothing during the day. Their educational programs—just sit for hours, no educator, no teacher, no therapy, nothing, just babysitting in the Dominican Republic.

Senator CRANSTON. Is there no form of control over the removal of American children under such circumstances?

Mr. WOODEN. Apparently not. The kids were taken to Guyana and kids were taken down to the Dominican Republic and they have been since 1971. I also have reports of American children that are placed in similar facilities like the Dominican Republic in Guatemala and Bermuda and Mexico. If you can make $300,000 off 30 kids a year and keep the costs down, why not move out of the country.

I think the American business taught us that. That is why shirts are being made in Korea and things like that, keep costs down and profits up.

Gordon Blossom is no exception.

Senator CRANSTON. Your principal recommendation for remedy is fiscal disclosure and audits.

Mr. WOODEN. Yes, sir.

Senator CRANSTON. And, undoubtedly, that is important. However, some of our other witnesses have indicated that even where audits have disclosed abuses, not necessarily I think abuses of children, but fraudulent abuses in terms of use of money for example: GAO investigation in 1977 and HEW's audits in 1976 disclosed illegal payments in the foster care program to profitmaking institutions and other illegalities—there apparently is not adequate followup. There are not enough outside advocacy groups like yours to monitor institutional abuses.

Do you have any recommendations in addition to the financial disclosure and audit recommendations that would enable us to deal with the problem?

Mr. WOODEN. Yes, I do. During the CHAMPUS scandal, I recommended to Senator Jackson and Senator Percy, and included it in my book, the creation of a health enforcement team, a team consisting of a doctor, a lawyer, a CPA, a nurse, and an educator that would go into facilities in all the States without prior notification.

I am happy to report that the Governor of the State of Arizona initiated that concept. The first place the team visited was called Circle S Ranch, where they found children from your State—from San Diego.

The program centered around having kids sit in a circle and simulate having sex with their parents. The owner was making $85,000 a year, his wife $65,000 and their son $35,000. They were making it big. They had been in existence for 22 years.

That concept of a health enforcement team at the State level not only put Circle S Ranch out of business, but accomplished something else. It sent the word out to other institutions in Arizona that a team with the power to investigate, the power to subpena, just may come knocking at their door. You know it would cost such a small sum of money for HEW to set up something similar on the Federal level. Right now it is crucial for the House and Senate to pass what was House bill 9400 last session, which would give congressional authority for the Justice Department to come in, if necessary, to protect the rights of institutionalized children. I remember a program we did for "Sixty Minutes," at a place called Camp Hill. We were interviewing a boy whose arms were disfigured, one hand totally deformed. This boy, who was denied his medication for his epileptic condition and subsequently got hung up on a hot radiator, held in his hands a letter from Stanley Pottinger, who headed up the Civil Rights Division, saying: "I am sorry to inform you that we do not have the authority to come into your State and investigate the conditions that you alleged."

Give them that authority, Senator Cranston. Do not allow the vested self-interest groups such as the National Association of Homes for Children—don't allow them to beat it down again this year.

I hope we can give you some help.

Senator **Cranston**. You indicated that the Eau Claire Academy in Wisconsin was receiving Federal funds under title XIX of the medicaid program for children placed there. What other children are placed in Eau Claire?

Mr. **Wooden**. Not to sound derogatory, but I call it Heinz 57 varieties. It does not matter. Dependent, neglected, mildly retarded, juvenile delinquent, status offender, handicapped, it does not matter. People that set up profitmaking corporations go after the kids. There is one fellow in Florida who would get on an airplane to personally pick up a CHAMPUS child.

Senator **Cranston**. Regarding the Sacramento Children's Home, the document that you attached to your testimony showed funds from Government agencies totaling over $1.3 million in fiscal year 1978 that went to that institution. What Federal funds were involved and under what Federal program?

Mr. **Wooden**. I am not sure of Federal funds, Senator. One thing I think should be looked into is the program. The Sacramento Children's Home is guilty of receiving large amounts of money earmarked for treatment and education, but in reality the children are dumped into the local public school system which realizes no remuneration from children's home. While the taxpayers in Sacramento and other cities are required to come up with more money for those kids dumped in the public school system, back at the ranch, so to speak, the $2,300 is just pocketed.

Senator **Cranston**. Thank you very much. You have been most helpful to us.

[The prepared statement of Mr. Wooden follows:]

U.S. SENATE SUBCOMMITTEE ON CHILD AND HUMAN DVELOPMENT

Senator Alan Cranston - Chairman

January 24, 1979

HUMAN RIGHTS & AMERICAN YOUTH

(Conditions in U.S. Children's Institutions)

STATEMENT - Kenneth Wooden, Author - Independent Investigative Reporter -
National Coalition for Children's Justice

Ms. Allen. Senator Cranston, thank you for inviting me to testify today at your hearings on the plight of institutionalized children.

My name is Mary Lee Allen, and I am representing this morning the Children's Defense Fund, a national, nonprofit, public interest child advocacy organization, created in 1973 to gather evidence about, and address systematically, the conditions and needs of children in this country.

My testimony this morning is based on our litigation challenging the placement of large numbers of children in inadequate or otherwise inappropriate institutions, or other residential facilities; on a Children's Defense Fund study of children in adult jails in nine States; and on our recently completed 3-year study of public responsibility for children placed in out-of-home care, in which we looked at policies and practices in seven States. We also did a detailed analysis of the Federal role regarding these children.

I have previously submitted a written statement which I would like to have entered into the hearing record, and I will summarize my testimony this morning.

Before beginning the summary, I want to thank you for your continuing efforts to improve the lives of all America's children. We consider the hearings today another evidence of your strong commitment to getting action on a national agenda for children.

We hope that the efforts of you and your colleagues to achieve meaningful reform in the child welfare system in the last Congress have paved the way for quick action in the 96th Congress.

This subcommittee first held hearings on the problems of children in foster care in 1975. Now, in 1979, we are still confronted with the presence of thousands of children in costly, often inappropriate placements in which they may be the victims of physical and psychological abuse.

It is particularly ironic to us that, in these days of fiscal conservatism, millions of unmonitored State and Federal dollars are being spent to maintain these children in residential care—although many of them could be better cared for with less costly in-home services or in less restrictive placements.

In beginning, let me note that we define institutional abuse broadly to encompass not only the physical and psychological abuse and neglect of children in institutions and other residential settings, but also the official neglect of children we found at all levels of government—the widespread failure of public systems charged with responsibility for children in out-of-home placement to protect their rights, insure them quality care while in placement, monitor their progress, and, as appropriate, insure them permanence.

I would now like to briefly summarize just four of the most relevant findings from our research and litigation.

First, we have found that institutional abuse occurs in all types of facilities. Although abuses in large congregate facilities may be more visible, abuse is not confined to the boundaries of large public institutions.

For example, in *Gary W.* v. *State of Louisiana*, referred to earlier by Assistant Attorney General Days, Children's Defense Fund together with local counsel and the invaluable assistance of the Department of Justice, successfully challenged the State's use of the federally financed AFDC foster care program to send hundreds of children away from their families and home communities to distant out-of-State residential placements that were often inadequate and inappropriate. These children were placed with State or Federal funds in atrocious conditions—but often in relatively small, privately owned residential treatment centers and group homes, some housing fewer than 25 children.

In other litigation and our study of children in adult jails, we have detailed the gross abuses of children placed in adult jails—often for crimes which would not have been crimes had they been adults; and sometimes for committing no offense at all, but rather they were being held in jail for want of more appropriate treatment facilities.

As a result of our recently completed study of public responsibility to children in out-of-home care, we estimate that there are between one-half and three-quarters of a million children in out-of-home placements and that at least 10,000 of these children are in placements in States other than the ones that have responsibility for them.

All of the child care systems—child welfare, juvenile justice, mental health and mental retardation and special education—place children, pay for them and make crucial decisions about what does and does not happen to them. And increasingly, all of these public child care systems place children in the same kinds, and frequently the same facilities: foster family homes, group homes, residential treatment centers, and various sorts of child care institutions.

We found good, bad, and even abusive programs in each type of setting, and it is important therefore that all children out of their homes are protected, whatever the size or label of the facility in which they are placed.

Second, we have found that the abuse and neglect of children in various residential facilities takes many forms. In our litigation and research we too have found evidence of severe physical and psychological abuses inflicted on children—sometimes under the guise of discipline or even treatment.

But our most recent study of children in out-of-home care has revealed more subtle forms of abuse as well. Children are abused when they are removed from their homes unnecessarily, placed in inappropriate facilities, and left there to linger indefinitely, often at Federal expense.

Children are abused when they are cut off from visits with their families, when there is no attempt to develop individual treatment plans for them, and when no attempts are made to reunite them with their families, or to provide other permanent homes for them.

It was discouraging to find that the State, in discharging its fiduciary responsibility to serve as custodian for children who have been separated from their families, has proven to be an often neglectful and sometimes abusive parent. Too frequently individual caseworkers and probation officers, often overworked and undertrained, do not know in any real sense the children for whom they are responsible. Nor frequently do they know what really goes on in the facilities in which they place children.

Third, we found that State and local oversight on behalf of children in out-of-home care is inadequate. Licensing, which theoretically constitutes a core component of the States' efforts to protect children, is ineffective. In many States, licensing standards do not address the adequacy of treatment; and frequently, the licensing process is isolated from other placement activities.

Partly as a result of this and partly as a consequence of the relatively limited range of specialized foster homes and day treatment programs, the inappropriate institutionalization of children is widespread. Indeed, in each of our study States, public officials openly acknowledged the overinstitutionalization of children. For example, children who were not mentally ill in State psychiatric hospitals, children abandoned on hospital wards long after the need for hospitalization ceased—often because Federal medicaid reimbursement is available.

And yet at the time of our visits none of the seven States studied had developed systemwide procedures to guard against such inappropriate placements, nor to spell out specific sanctions for institutional abuses.

Another serious and destructive manifestation of the public neglect of children is the failure of States to periodically review the progress of individual children in care and the quality of services they are receiving.

Most significantly, we also found that the Federal Government often exacerbates the problems just described. We found that in our study the policies and practices that result in the public neglect and abuse of children are in fact often encouraged, if not precipitated, by Federal policies and programs.

The availability of Federal dollars often determines what a State does and does not do. Fiscal incentives and disincentives implicit in Federal programs therefore become extremely significant in shaping the services available at the State and local levels, as do specific protections, regulations and monitoring procedures.

Yet our review of over 34 Federal programs which impact directly and indirectly on children out of their homes revealed that the national policy toward these children affords few protections to them and provides for little Federal monitoring of State and local performance.

I have listed a number of examples in my testimony of evidence of Federal failures. Let me mention just a couple here. For example, until just recently virtually no emphasis has been placed in the implementation of the Child Abuse Prevention and Treatment Act on protecting children from institutional abuse and neglect, regardless of the act's clear applicability to such abuse. Although it has been said again and again this morning that the States are required under that act to establish procedures to monitor such abuses, our review of State child abuse and neglect reporting laws showed only few specific references to monitoring the institutional abuse of children.

Neither of the two major Federal foster care programs, the AFDC foster care program or the Child Welfare Services program, requires efforts to prevent the unnecessary removal of children from their homes, requires placement in the least restrictive setting appropriate to a child's needs, or requires a dispositional review for children in care by an independent body not involved in the provision of direct services.

Instead, the AFDC foster care program provides a disincentive to the development of strong family support programs, and thus subjects more children to the risk of public neglect and institutional abuse.

That program currently provides unlimited Federal reimbursement to the States only for the room and board of certain AFDC eligible children; not for services to prevent placement, to reunite families, or services related to adoption when reunification is not possible.

There has also been a striking absence of Federal compliance efforts with regard to children in out-of-home care. In some instances this has been because responsibility for enforcement has been inadequately defined by statute. For example, although the litigation experience of the Civil Rights Division of the Department of Justice has shown that the basic constitutional and Federal statutory rights of institutionalized persons, including children, are being violated on a systematic and widespread basis, there is currently no legislation specifically authorizing the Attorney General to initiate litigation when such rights are violated.

There are two steps the 96th Congress could take immediately to begin to remedy the plight of these institutionalized children we are discussing today, as well as other children in out-of-home care:

First, the 96th Congress must pass legislation similar to that approved by the House of Representatives in 1977, and given extensive consideration by the Senate both in S. 1928, and as part of H.R. 7200, which would insure that the Federal dollars spent are in fact furthering the well-being of children.

It is crucial that any bill adopted by Congress:

Erases current Federal fiscal incentives to remove and maintain children out of their own homes;

Provides increased targeted funds for preventive and reunification services, and Federal reimbursement for adoption subsidies;

Provides protections such as periodic reviews of the status of children in care to prevent unnecessary and inappropriate placements, and to insure placement of children in the least restrictive settings appropriate to their needs and within reasonable proximity to their families;

And provides children and their families with due process protections, both prior to and while in placement.

We also urge the 96th Congress to act on legislation recently reintroduced in both the Senate and the House, S. 10 and H.R. 10, which would give the Attorney General standing to bring cases involving violations of the constitutional and Federal statutory rights of institutionalized persons, both children and adults.

Speedy enactment of these two items of unfinished business from the 95th Congress could help to set the 96th Congress on a track toward a national policy that is both humane and fiscally responsible.

The problems confronting institutionalized children and other children in out-of-home care require immediate action. We stand ready to help you and others in this Congress to move forward with these reforms.

Thank you.

Senator CRANSTON. Thank you very, very much for your helpful testimony.

We have some questions. We will ask you the questions in writing in order to expedite this.

[The prepared statement of Ms. Allen follows:]

TESTIMONY

OF

MARY LEE ALLEN

CHILDREN'S DEFENSE FUND
WASHINGTON, D.C.

BEFORE THE

SENATE SUBCOMMITTEE ON CHILD
AND HUMAN DEVELOPMENT

ON

INSTITUTIONALIZED CHILDREN

January 24, 1979

Mr. Chairman and Members of this distinguished Committee:

Thank you for inviting me to testify today at your hearings on the plight of institutionalized children.

I am testifying on behalf of the Children's Defense Fund, a national, nonprofit, public interest child advocacy organization created in 1973 to gather evidence about, and address systematically, the conditions and needs of children in this country. CDF has issued a number of reports on specific problems faced by large numbers of these children. We seek to correct problems uncovered by our research through the monitoring of federal and state administrative policies and practices, litigation, the dissemination of public information and the provision of support to parents and local community groups representing children's interests.

Senator Cranston, before I present our testimony I want to thank you and your colleagues for your continuing efforts to improve the lives of all of America's children. We have deeply appreciated the opportunity to work with you in the past on child care, child welfare and other issues, and we consider the hearings today another evidence of your strong commitment to getting action on a national agenda for children.

We hope that the efforts of you and your colleagues to achieve meaningful reform in the child welfare system in the last Congress have paved the way for quick action in the 96th Congress.

This subcommittee first held hearings on the problems of children in foster care in 1975. Now, in 1979, we are still confronted with the presence of thousands of children in costly, often inappropriate placements in which they may be the victims of physical and psychological abuse. It is particularly ironic to us that, in these days of fiscal conservatism, millions of unmonitored state and federal dollars are being spent to maintain these children in residential care--although many of them could be better cared for with less costly in-home services or in less restrictive placements.

It is our hope, as we know it is yours, that by working together with the Congress and the executive branch this year, we can, for once and for all, make a start on addressing these problems by passing legislation which would protect these most vulnerable children.

Our testimony today is based on our litigation challenging the placement of large numbers of children in inadequate or otherwise inappropriate institutions or other residential facilities, on a CDF study of children in adult jails, and on our recently completed three year study of public responsibility for children placed in out-of-home care by the various child care systems. Let me note that we define institutional abuse broadly to encompass not only the physical and psychological abuse and neglect of children in institutions and other residential settings, but also the official neglect of children we found at all levels of government--the widespread failure of public systems charged with responsibility for children in out-of-home placement to protect their rights, ensure them quality care while in placement, monitor their progress, and, as appropriate, ensure them permanence.

With this as a context, I would first like to highlight the problems addressed by our litigation.

Institutional Abuse Occurs in All Types of Facilities

In 1976 in Gary W. v. State of Louisiana, 437 F. Supp. 1209 (E.D. La. 1976); 429 F. Supp. 711 (1977); 441 F. Supp. 1121 (1977), the Children's Defense Fund, together with local counsel (Rittenberg and Wilkes of New Orleans) and the U.S. Department of Justice, successfully challenged the state of Louisiana's use of the federally-financed AFDC Foster Care Program to send hundreds of children away from their families and home communities to distant out-of-state residential placements, to facilities that were often inadequate and inappropriate to their needs.

This case involved children with a range of special needs. Some suffered from handicaps, either mental retardation, emotional disturbances or physical disabilities; some were delinquents; still others were just hard to place foster children (e.g., too old or considered the wrong color). What they shared in common was that, while they were placed in a variety of different types of facilities, all of them were placed with state or federal funds, all of them were completely cut off from their families and loved ones, and none of them had individualized case plans as required by federal law.

Many of the children were placed by the state in the most atrocious conditions. The court found that in certain facilities, children were physically abused, handcuffed, beaten, chained and tied up, kept in cages, and overdrugged with psychotropic medication.

I should point out that these particular atrocities did not occur in giant public warehousing institutions, about which Congressional committees have heard much testimony in the past. They occurred in relatively small, privately owned residential treatment centers and group homes, some of which had fewer than 25 children. One such home, Peaceful Valley, was visited by a state official following the filing of the case. He reported to the director of the state agency:

> I had an eerie feeling. The room where most of the children were kept was rather dark and though most of them were awake I was not allowed in the room.... Evidently most of the children are confined to their rooms and care and management is designed to cause as little work for the operator as possible.

A mother testified at trial that her son, who could walk when he was placed in this home by the state, lost the use of his legs while there.

Clearly, for this group of vulnerable children who have been separated from their families that ordinarily would act to protect them, abuse is not confined to the boundaries of our large public institutions. This is not to say, however, that the abuse of children in large institutions does not continue to be a problem. In fact, in other CDF litigation we have challenged placement practices and/or conditions in some of these large institutions--the Oakley Training School, a minimum security institution for older delinquent males in Raymond, Mississippi (Morgan v. Sproat, 432 F. Supp. 1130 (S.D. Miss. 1977); the Hudspeth Retardation Center in Whitfield, Mississippi (Doe v. Hudspeth, No. J75-36 (c) (S.D. Miss.); and St. Elizabeth's Hospital in the District of Columbia (Poe v. Califano, C.A. No. 74-1800 (D.D.C., September 25, 1978)).

The court in Morgan v. Sproat found that the rights of Oakley residents to treatment and to due process of law had been violated by existing conditions at the training school. The court specifically found that confinement of youths in the Intensive Treatment Unit for punishment constituted cruel and unusual punishment. There were also findings as to the unsuitability of living arrangements, and the inadequacy of health, educational, recreational and vocational programs at the training school. One of the plaintiffs in the case involving the Hudspeth Retardation Center had been subjected to serious physical abuse at the Center, including electroshock, physical beatings and excessive and unwarranted drugs. Although he had been at the facility for three years when the suit was filed, he had never received any psychological evaluation or assessment of his needs, and had not received educational services or physical recreation of any kind. While at the Center he had lost his ability to speak words previously known, communicate his needs, dress himself and control his bodily functions, all things he could do when admitted to the institution. Poe v. Califano challenged the constitutionality of the District of Columbia statute which allowed the placement of children under the age of 18 in public mental hospitals by their parents, without procedural protections to ensure that the child needed in-patient care and was not susceptible to treatment in a less restrictive setting.

In a lawsuit in South Carolina, Larry W. v. Stone, C.A. No. 74-986 (D.S.C.), CDF challenged the placement of South Carolina children in county jails maintained for adults. Plaintiffs were three white and three black youths who were confined with adults in segregated county jails. Four of the youths had been raped and one sexually assaulted. All had been brutally beaten. A study subsequently conducted by CDF's Juvenile Justice Division revealed that such abuses were not confined to South Carolina.[1] Children were being held in adult jails in each of the nine states visited.[2] The vast majority of these children were not detained for violent crimes; 17.9 percent of them had committed status offenses, that is actions which would not be crimes for adults, such as truancy or running away; and some of them had committed no offenses at all but were being held in jail for want of any more appropriate treatment facilities. The conditions in most of the jails in which children were found were abysmal--old, dirty and decrepit, with insufficient sanitary, food or medical facilities. Fewer than 10 percent of the jails reported any educational facilities; and only 12.4 percent reported any recreational facilities.

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[1] For a further description of the study findings, see Children's Defense Fund, Children in Adult Jails (CDF: Washington, D.C., 1977).

[2] Florida, Georgia, Indiana, Maryland, New Jersey, Ohio, South Carolina, Texas and Virginia.

Which Children Are Affected

Our more recent study of children without homes in seven states[3] also revealed repeatedly that children were removed from their homes unnecessarily, placed in inappropriate facilities, often at great distances from their families, and left there to linger indefinitely often at federal expense.[4] Overall we estimate that there are between one half and three-quarters of a million children in out-of-home placements, and that at least 10,000 of these children are in placements in states other than the ones which have responsibility for them. In a stratified random sample survey we conducted of 140 counties, child welfare officials reported that over 20 percent of the children in their care had been in care six years or more; over 50 percent had been in care two years or more. Our study and many others, including studies by the General Accounting Office and the HEW Audit Agency, have documented

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3/ Arizona, California, South Carolina, South Dakota, Massachusetts, New Jersey and Ohio.

4/ For a detailed description of our findings, see Children's Defense Fund, Children Without Homes: An Examination of Public Responsibility to Children in Out-of-Home Care (CDF: Washington, D.C., Forthcoming February 1979).

the poor conditions in which many of these children are placed and left to linger.[5/]

In our study we looked not only at children in the child welfare system, but also at the children who have become the responsibility of other public child care systems. All of the child care systems--the child welfare system, the juvenile justice system, the mental health system, the mental retardation system, and the special educational system--place children in residential out-of-home care, pay for them and make crucial decisions about what happens and does not happen to them. And increasingly, all of these public child care systems place children in the same kinds of facilities: foster family homes, group homes and various sorts of child-care institutions. Thus, it is not unusual to find in a single residence, children who have entered care in a variety of ways. For example, a moderately retarded youth who has returned to the

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[5/] See, for example, General Accounting Office, Children In Foster Care Institutions: Steps Government Can Take to Improve Their Care (Washington, D.C.: GAO, February 1977); and reports by the HEW Audit Agency's Philadelphia Regional Office, Review of AFDC Foster Care Program Administered by the Department of Public Welfare, Commonwealth of Pennsylvania (Washington, D.C.: HEW Audit Agency, Audit Control No. 60253-03, May 1976), and Report on the Aid to Families with Dependent Children Foster Care Program, Commonwealth of Virginia (Washington, D.C.: HEW Audit Agency, Audit Control No. 60253-03, June 1976).

community after a number of years in an institution for the mentally retarded; a youth who has been determined by the court to be a person in need of supervision and assessed by the court psychiatrist to have some emotional difficulties; a ten-year-old youth who has been voluntarily placed by his mother because she had to be hospitalized temporarily and could find no one to care for him at home; or a second grader and his two older siblings who were removed from a home where repeated abuses have occurred, all may be placed in the same group facility.

In reality, distinctions among group homes, residential treatment centers, special schools, child care institutions and other specialized institutions become blurred. Good, bad, and even abusive programs are found in each type of setting, and it is important that all children out of their own homes are protected, whatever the size or label of the particular facility in which they are placed. The potential for abuse in a facility does not turn on how a child got there. As a result of the movement toward deinstitutionalization, children are increasingly being placed in smaller facilities. These children too need to be protected from abuse.

Abuse and Neglect Takes Many Forms

Abuse and neglect of children in residential facilities takes many forms. The GAO, in a review of 18 facilities housing 13 or more children placed under the foster care provisions of the AFDC program, observed serious deficiencies at seven of the 18 facilities they studied. The deficiencies included children sleeping on mattresses on the floor in cramped and dingy rooms, children's beds pushed up against gas heaters that were operating at full power even though it was a hot summer day; dirty and unsanitary sleeping, living and kitchen areas; and inadequate control over prescription drugs, which in two institutions were left in shoe boxes on desk tops.[6] In our study states too, CDF found evidence of punitive and unmonitored seclusion and of severe behavioral restrictions.

There are more subtle forms of abuse as well. Children are abused when they are cut off from visits with their families, when they are placed in care and left indefinitely without any attempt to develop an individual case plan or treatment plan for them, and when no attempts are made to reunite them with their families or provide

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6/ Children in Foster Care Institutions: Steps Government Can Take to Improve Their Care, pp. 25-26.

other permanent homes for them. Our study revealed that the further away a child in care is placed from a family setting, the less caseworker-child contact takes place. For example, 64 of the 140 counties in our survey reported written policies requiring caseworker-child contact. But while 46 percent of the counties reporting required such contact if a child is in a foster home, only 30 percent required contact if a child is in a group home, 25 percent if the child is in an institution and only 12 percent if the child is in an out-of-state placement. Of the 50 states we surveyed concerning out-of-state practices, only one-third reported any efforts to visit or specifically review out-of-state facilities in which they place children, beyond requiring that the facilities be licensed.

It was discouraging to find that the state, in discharging its fiduciary responsibility to serve as custodian for children who have been separated from their families, has proven to be an often neglectful, and sometimes abusive parent.

Those with direct responsibility for the children, caseworkers and probation officers are overworked (we found on one Indian reservation a social worker with a caseload of 175 children), undertrained (county staff reported getting little help in handling frequently complex family situations, although they did have training sessions on filling out forms), and strangely, unrewarded for responding to the children (one probation officer even reported it was "better" for his advancement if he spent an afternoon writing a report on a child than being with the child.) As a result the caseworkers typically do not know in any real sense the children for whom they are responsible. Nor frequently do they know what really goes on in the facilities, particularly the institutional facilities in which they place the children.

State and Local Oversight Is Inadequate

Licensing, which theoretically constitutes a core component of the states' efforts to protect children, is ineffective. Even in our two study states that had recently modified licensing procedures and regulations, licensing efforts were still beset with enforcement failures, and the licensing process was isolated from other placement activities. The GAO study referred to earlier concluded that licensing and placing agencies did not enforce licensing standards, and that licensing activities did not ensure that facilities were maintained at acceptable levels. In many states, licensing standards do not address the adequacy of treatment or, for that matter, whether an institution is providing any treatment at all.

231

Compounding the problem, state placing agencies have been found to use unlicensed facilities. And HEW audits of the AFDC Foster Care Program have revealed that frequently children were placed in facilities and left to remain there for years, without any reevaluations of the qualifications of the facility, although such reappraisals were required by law.

In the Gary W. case, CDF obtained through discovery a report prepared by a supervisory official of the Louisiana Department of Family Services following an investigatory trip to a number of out-of-state institutions in which Louisiana children had been placed. The report acknowledged such state neglect, concluding:

> ...I have tried to convey the feeling of loneliness and abandonment that our children seem to experience....(O)ur agency seems to lose essential contact with our children once they are placed out of state. Any such contacts as we do have with them seem to be incidental, not on a purposeful and sustained basis....Indeed, the children with whom I was acquainted had progressed, some perhaps enough to be considered for alternate type care. Yet, some simply linger indefinitely in these institutions. I realize this implies dereliction on our part. 7/

7/ Gary W. v. State of Louisiana, No. 74-2412 (E.D. La.), Plaintiffs' Exhibit 94, p. 4.

Partly as a result of this, partly as a consequence of the relatively limited range of specialized foster homes, day treatment programs or genuinely community-based homes, the inappropriate institutionalization of children is widespread. Adolescents with or without special needs are particularly vulnerable to such placements, and so are younger children with handicapping conditions. Indeed, in each of our study states, public officials openly acknowledged or shared in-house reports documenting the over-institutionalization of children; children who were not mentally ill in psychiatric hospitals, children who were seriously mentally ill in facilities with no specialized staff, children who were not retarded in facilities for the retarded, ambulatory handicapped children in pediatric nursing homes for non-ambulatory children, children abandoned on hospital wards long after the need for hospitalization ceased. In a variant of the problem we also found large numbers of children placed in facilities far from their own homes, communities, and states; children from Maine sent to Oregon, children from Washington sent to Texas. And yet at the time of our visits none of the seven states studied had developed system-wide procedures to guard against such inappropriate placements, nor to spell out specific sanctions for institutional abuse.

Another serious and destructive manifestation of the public neglect of children is the failure of states to periodically review the progress of individual children in care and to see that they get the services and care to which they are entitled. Although states have made recent strides in this area, at the time of our visits only one of our study states had a statutory requirement that the cases of children in out-of-home care be reviewed periodically by a body independent of the caregivers.

The Federal Government Exacerbates the Problem

Most significantly, we found in our study that the policies and practices that result in the public neglect and abuse of children are not only reflected locally and at the state level, but are in fact often encouraged, if not precipitated, by federal policies and programs. As we all well know, the availability of federal dollars often determines what a state does and does not do. Fiscal incentives and disincentives implicit in federal programs therefore become extremely significant in shaping the services available at the state and local levels, as do specific protections, regulations and monitoring procedures required by federal programs. Crucial too is the extent to which the federal government monitors and enforces compliance with its regulations.

However, our review of the 34 federal programs which impact directly or indirectly on children out of their homes, in institutional care as well as less restrictive settings, revealed that the national policy toward these children affords few statutory protections to them, and provides for little federal monitoring of state and local performance. It permits the federal government year after year to claim ignorance about the magnitude of the problem of public abuse and neglect of children. For illustration let me share with you just several specific examples.

-- Current federal policies fail to ensure adequate procedural and substantive protections to children at risk of removal and in placement, or to their families.

In the implementation of the Child Abuse Prevention and Treatment Act, virtually no emphasis has been placed on protecting children from institutional abuse and neglect, regardless of the Act's clear applicability to such abuse. Federal child abuse funds are just now being used for the first time for research and demonstration programs related to institutional abuse. States are not yet required to establish procedures for monitoring such abuses in order to be eligible for funding under the program.

Neither of the two major federal foster care programs, the AFDC Foster Care Program funded under Section 408 of Title IV-A of the Social Security Act, nor the Child Welfare Services Program funded under Title IV-B, requires that prior to a child's removal from home, the family be offered preventive services (except in emergency situations); that the child be placed in the least restrictive setting appropriate to his needs; and that the child be placed within reasonable proximity to his home and community.

Further, neither program requires a dispositional review for children in out-of-home care by an independent body (not involved in the provision of direct services) to ensure children do not linger indefinitely in foster care without permanent homes and to ensure that someone monitors the quality of care they receive.

-- Federal funding patterns act as disincentives to the development of strong family support programs, despite the fact that these would reduce the numbers of children at risk of public neglect and institutional abuse.

The AFDC Foster Care Program provides unlimited federal reimbursement to the states for the room and board of certain AFDC-eligible children in out-of-home care. The program does not pay for services to prevent placement, services to reunite families, or services related to adoption when reunification is not possible. It does not condition federal reimbursement on the length of time a child is in care without good faith efforts to ensure the child permanence. States in fact have less of an incentive to move the federally eligible children out of care, than they have to move those children for whom they are carrying the whole expense. Furthermore, the Child Welfare Services Program, which theoretically could provide such services, has consistently been funded at a level far below its authorized level of $266 million, and these funds have been used primarily for out-of-home care.

-- There has not been significant federal attention to the quality and comprehensiveness of care for children in residential facilities.

The Juvenile Justice and Delinquency Prevention Act requires that children placed in adult correctional facilities have no regular contact with adult prisoners. Yet, there has been virtually no coordination between this Act requirement and the Title I education program for children in institutions for neglected and delinquent children, under which 14,000 children were counted as being in adult correctional facilities in Fiscal Year 1977.

There has been no coordinated attempt to relate the total federal dollars going into institutions--for food, education, and health care, for example--to the needs of children in those facilities. Furthermore, there has been no federally funded research to trace the impact of deinstitutionalization efforts across systems on the children involved.

-- There has been a striking absence of federal compliance efforts with regard to children at risk of removal or in out-of-home care.

In some instances, responsibility for enforcement has been inadequately defined by statute. The litigation experience of the Civil Rights Division of the Department of Justice has shown that basic constitutional and federal statutory rights of institutionalized persons, including children, are being violated on a systematic and widespread basis. Yet, there is currently no legislation specifically authorizing the United States to initiate litigation when these rights are violated.

In part, the absence of useful national information about children out of their homes and about the impact of relevant federal programs prevents meaningful monitoring and evaluation efforts. Although HEW is responsible for the majority of federal programs affecting children in out-of-home care, it knows little about the children in various foster care settings or about how state and local agencies are discharging their responsibilities for them.

What Can Be Done

There are two steps the 96th Congress could take immediately to begin to remedy the plight of these institutionalized children we are discussing today, as well as other children in out-of-home care:

1) Pass legislation (similar to that approved by the House of Representatives in 1977 and given extensive consideration by the Senate both in S. 1928 and as part of H.R. 7200) which would ensure that the federal dollars being spent are in fact furthering the well-being of children. It is crucial that any bill adopted by Congress:

   - Erases current federal fiscal incentives to remove and maintain children out of their own homes;
   - Provides increased targeted funds for preventive and reunification services and federal reimbursement for adoption subsidies;
   - Provides protections such as periodic reviews of the status of children in care to prevent unnecessary and inappropriate placements and to ensure placement of children in the least restrictive settings appropriate to their needs and within reasonable proximity to their families; and
   - Provides children and their families with due process protections both prior to and while in placement.

2) Act on legislation recently reintroduced in both the Senate and the House (S.10 and H.R.10) which would give the Attorney General standing to bring cases involving violations of the constitutional and federal statutory rights of institutionalized persons, both children and adults.

Speedy enactment of these two items of unfinished business from the 95th Congress could help to set the 96th Congress on a track toward a national policy that is both humane and fiscally responsible.

The problems confronting institutionalized children and children in other out-of-home settings demand immediate action at the national level. These children can wait no longer!

The Children's Defense Fund looks forward to working with the subcommittee and other members of Congress to achieve these modest but critical gains for the nation's most vulnerable children. Thank you for the opportunity to share our findings and recommendations with you.

Senator **Cranston**. We have fallen badly behind because of the desire to hear fully from Kenneth Wooden and others.

I want to welcome Senator Riegle to this committee. He is a full partner in this effort who totally shares the concern that so many of us have about children and their need for appropriate care in so many respects.

He has been exceedingly helpful on legislation that we have been working on up to now. I know that together he and I and others working together can deal with this problem. It is going to take some hard work and some real digging until we know exactly what the circumstances that we are confronting are. You have given us some incredible testimony already today about the horrors on abuse of children. We have to find what we can do to expand our capacity and use whatever authority is required to end these sorry practices.

I regret that I have to leave for other purposes. Don will carry on at this point.

Don, thank you very much for coming.

Senator **Riegle**. Mr. Miller, would you like to proceed.

Mr. **Miller**. I am here representing the National Center for Action for Institutions and Alternatives, and National Youth Worker's Alliance.

I will summarize my testimony.

Senator **Riegle**. What we will do is make your whole statement a part of the record.

If you can summarize, I would appreciate it. I want to make sure everybody has a chance to make some remarks in addition to their prepared statements. That will help us.

Mr. **Miller**. I will not try to lay out in detail the stories and atrocities that are occurring. I would like to say they are occurring. It is unfortunate that in these days we have to talk about such things happening.

I recently toured State training schools in Tennessee as part of a lawsuit there. We found evidence of a great deal of abuse: beatings, rapes, random punishment that would make Marquis de Sade wince. We recently completed a few days at Riker's Island in New York and found hundreds of 16- and 17-year-olds which in New York are considered adults in cages being dealt with in conditions that would not do credit to anyone of humane impulses.

Senator **Riegle**. Did you say cages?

Mr. **Miller**. So-called adolescent remand centers, basically a system of cell blocks for up to 1,000 people in cells. There were horrific conditions. I recall seeing that facility in 1972 at the request of Mayor Lindsay, being brought down from Massachusetts to look at it 3 weeks or so before it was opened, they wanting some suggestions as to how they could make it work.

My only suggestion is to blow it up before they start using it because it would create more crime in the streets of New York than anything an organized crime group could sit around the room and design.

Unfortunately, they are using it, and, of course, it looks now 4 years later like something that was built in the late 1800s. It is horrific.

I would like to dwell on one issue that I do not think has been presented yet—just in terms when Congress and States consider this abuse of children—by way of some testimony and of all solutions to this problem.

The misuse of children continues at a high rate. It is very much tied in, it seems to me, to a pattern of professionalism and irresponsibility of many involved in child care establishments in this Nation. I do not think it is any accident that a State like New York, for example, which probably has the most sophisticated child care establishment, most sophisticated psychiatric association, psychologists, social workers, you name it, that side by side with that you have some of the worst institutions for human neglect that the Western World has known.

Attica, Willowbrook, Riker's Island, The Tombs. I remember interviewing a researcher from Europe a few years ago who visited Tombs and said he had not seen anything like Tombs anywhere in the world, including India and Africa. It is not an accident that side by side with that professional establishment one has these institutional arrangements. In fact, it is symbiotic relationship. It is related to the lack of consumerism we have in this whole area of child care, of governmentally given services, human services, because, in fact, the people who are giving the services make the diagnoses, give the treatment, decide whether it works or not, set the rates, do their own regulating, and, in fact, it is a very closed system, so Congress should be very leery of those who come here and say the answer alone is not having enough qualified people.

Certainly one needs qualified people, but I see no evidence in terms of institutional child abuse that having qualified people guarantees that children will not be abused.

You find professional jargon being laid upon 19th century ideology. Within that system you find an old boys club, an old girls club whereby the regulators formerly ran the agencies and the agencies become the regulators. They go to the same NASC meetings and the same child welfare league meetings.

It is a system that is virtually impervious to self-regulation. It is all bound up within itself.

I do not mean by that to demean the people involved in it. I think it is full of altruists. Unfortunately, children cannot be dependent upon altruism of many people. They have to be dependent upon something more constant than that.

As I believe David Rothman recently commented, we have to be aware that those who become objects of our concern eventually become objects of our coercion. That certainly has been true with reference to the child welfare system.

There are a few very specific things I would like to suggest. That Congress not be fooled into believing diagnoses attached to these children. In fact, diagnoses are not scientific for the most part. The deprived, the neglected, delinquent, emotionally disturbed—there are elements of scientific fact to them. But children become labeled, not in terms of those sorts of studies. They become labeled in terms of what agency they happen to pop into first, and the labels are attached according to bureaucratic and managerial needs, not according to individualized needs of children.

One would view child welfare system as a series of large bureaucracies which applies diagnoses and labels on the basis of bureaucratic needs rather than on the basis of any punitive individualized needs of the children or adolescents themselves. For example, one of the major findings of the Center for Criminal Justice, Harvard Law School, in their study of uses of detention, was that a teenaged offender tended to be kept in locked detention, not on the basis of the seriousness of the crime, or even on the basis of possible emotional instability. Rather, the major determinant as to whether a youngster was locked up or sent home, had to do with the number of vacant beds in the detention center on the night the youth was arrested. If there were cells, he was detained. If there weren't any, he was released. Similarly, youngsters who others might view as "psychotic," quickly became "character disorders" when they became management problems in the more posh State residential treatment facilities.

The change in diagnosis of course dictates a shift in the quality of care—both related to bureaucratic and management needs, not to anything scientific or in fact "professional."

It is out of this pattern that abuse and neglect of children in our care system originates. Perhaps the most glaring examples of this is in the general and massive use of isolation rooms in the majority of our juvenile correctional and child care treatment facilities. The use of isolation is a management tool having nothing to do with care or treatment. Its debilitating effects are systematically ignored or rationalized. The final insanity of it is most obvious in its repeated use with adolelscents who are considered "suicidal." Virtually all the literature shows that a person is most likely to commit suicide in isolation, yet it becomes the prescription for the disturbed or suicidal youngster. Nowhere in the professional research can one find a therapeutic justification for prolonged use of isolation rooms. Yet, they remain in use in most State institutions in every State in the Union, often blessed and validated by "helping" professional social workers and psychologists acting in their managerial roles. When there is little accountability, and when one has basically captive clientele, one can anticipate that those who are the objects of our concern will ultimately become the objects of our coercion. Such as been the history of child care in this country. Calling "the hole," intensive care hardly alters the situation.

If I would have one bit of advice to the members of this subcommittee in their investigation of institutional child abuse, it would be to trust your "layman's" judgments and perceptions. By the same token, take the advice of child care "professionals" with a large grain of salt.

I think that Harold Laskey's idea that professionals should be on tap but not on top applies here. Aristole also comments that the best judge of the meal is not the chef but the guest.

In fact, the decisions to be made in this field have to be lay persons' decisions. They have to be family decisions. This field should no more be run by those who are presently running it than a family in need of medical services or in need of psychiatric services should be run by a psychiatrist or medical doctor who comes in and makes all the decisions and decides on the success or the lack of success.

We need a consumers' movement.

It is very difficult when you have a captive population, be they delinquent, captive by virtue of their crimes or delinquencies, or captive by virtue of their economic deprivations as is the case with so many in the child welfare field.

I do not think that the answer to misuse of children will be found in the perennial response you will hear I am sure in these halls.

One, we do not have enough funding and, two, we do not have enough qualified personnel.

This field has much too much funding for what it does. Pennsylvania at present to incarcerate a juvenile in State reform school, by their own figures, the Department of Public Welfare's own figures, $32,000 per kid per year. The Spofford Home in New York City, detention center which has been the subject of exposés for misuse and abuse of children for the last 10 years, is presently $65,000 per year.

Average cost of State-run training schools for delinquent youth in this country is in excess of $20,000 per year.

There is one in Pennsylvania that is $49,000 per year.

I think Ken Wooden pointed to the profitmaking groups that are on this gravy train, but one should not look only at profitmaking. There are a great deal of gains being made within the nonprofit sector.

I point particularly to a group called The National Association of Homes for Children, which is a consortium of nonprofit homes which has recently retained Hill and Norton to lobby this bill with reference to their needs.

By their own figures, they claim to be in this for $280 million per annum in terms of care for kids.

I was flattered to see in the President's address to that group that he listed among the enemy Mr. Wooden, myself, Congressman George Miller, Office of Juvenile Justice, and Children's Defense Fund. I hope if we are the enemy, they will send me some sort of plaque we can hang on our wall as a badge of honor.

With reference to dealing with child abuse, it is not going to happen to regulations. I have been in State agencies in a number of States, and I know the numbers games played with regulations, and for the most part they are not enforced. It is because this field is not one to enforce regulations. If one wants to stop child abuse, one can do it through executive action. We do not need more regulation. We need more will. If I wanted to stop child abuse in one of our agencies, for instance, I think we are able to do it.

I will give a quick example. In Massachusetts we made it clear to the press that any responsible member of the press would be welcome in any institution, in any room, in any facility, at any time of the day or night or morning to talk to any kid at anytime whenever. When we had an incident, we exposed our own incidents, we invited the press in to interview the kids who had been beaten. When kids were being set up to escape, to embarrass our so-called permissive policies, we invited the press to interview them. We exposed our own system.

I agree very strongly with Senator Cranston's earlier comment that if the public were aware of what is going on, they would demand changes.

In Massachusetts we did have that demand for change, and we were forced to close all our State training schools. Senator Backman fought very hard to bring about those changes in Massachusetts, and it is very clear there is deterioration setting in. The department is keeping the press out. They are firing people who whistle-blow.

Those are the issues. They are bureaucratic issues. They are issues of lack of will.

Finally, I would like to say that I had the opportunity yesterday to sit in on a meeting over at the Office of Child Abuse with reference to programs as to how they are going to investigate child abuse. I believe they will be testifying in some detail today.

It seems to me those grants are ill-informed at the outset. Basically grants from the Office of Child Abuse were only given to agencies to investigate their own abuse and it is not going to happen. No matter how it is cut, what kind of jargon it is placed in, it is not going to happen.

We looked at D.C., we had a D.C. group explain their plan to investigate their institutions, and we heard the statement that, of course, they were not going to investigate the use of solitude because that is all presently within regulations. To suggest that one could investigate child abuse in one institution and not look at the greatest abuse, which is the use of isolation of children in this country, is ridiculous.

I challenge anyone in the field, professional or otherwise, to present one iota of scientific data which shows use of isolation in any way helps anyone other than in managerial or a bureaucratic way. It is managerial or controlled mechanism and has nothing absolutely to do with youngsters.

It seems to me a lot could be done. But perhaps regulatory route is not the route to go.

I would suggest that there perhaps be more support from Congress for executives willing to take strong actions.

Thank you.

[The prepared statement of Mr. Miller follows:]

January 24, 1979

SENATE

SUBCOMMITTEE ON CHILD
AND
HUMAN DEVELOPMENT
OF
HUMAN RESOURCES COMMITTEE

TESTIMONY OF DR. JEROME G. MILLER

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I appreciate the opportunity to appear before this committee and to respond to the subcommittee's request, seeking information about specific problems facing institutionalized children, current activities at various levels of government designed to deal with problems of maltreatment, and the inappropriate institutionalization of children. I would also like to address myself to possible mechanisms for dealing with these problems.

The problems facing institutionalized children in the United States are serious and probably growing - despite rhetoric to the contrary. One would have hoped we had passed the period of Dickensian misuse of children, and that it would be hysterical exaggeration to focus on a few unusual and isolated incidents of child abuse in institutions. Such is not the case however. Children throughout the United States continue to be methodically abused and misused in institutional programs, both state-run, and under private auspices. In addition, the abuse occurs not only in the juvenile justice system where so many are held inappropriately in institutions as "delinquent", but it occurs to a similar extent in the so-called child welfare institutions and foster care systems wherein the "crime" of the youngster is primarily that of being neglected or dependent.

With reference to the types of abuse, one need not confine oneself to the more sophisticated concepts such as "psychological" abuse, or the abuse of "unmet needs". Unfortunately, one can still speak clearly of the rudimentary, easily identifiable abuse which is embarrassing to speak of because its existence demeans us all. Over the past few years I have had occasion to be involved in the investigation of institutional mistreatment of youngsters in a number of states. I have helped prepare or testified in cases in Federal and state courts in Texas, Wisconsin, Tennessee, Massachusetts, California, West Virginia, Illinois, Maryland, Utah, Missouri, and Rhode Island. I have recently returned from a week-long visit to the state training schools in Tennessee, where there is overwhelming evidence of large scale abuse, including beatings, macings, rape, random punishments, use of threats,etc. Within the past week, I have had occasion to spend a few days at Rikers Island prison in New York City, where hundreds of 16 and 17 year old youngsters are daily subjected to a system of caging which aside from resulting in a good deal of physical abuse and assault, probably contributes more to formation of criminal careers than any program which might be designed by a Cosa Nostra for that purpose.

I'm sure this committee is aware of the many misuses of children and adolescents in certain child care and residential treatment units under state and private auspices. This is particularly true with reference to many of the more recent so-called "aversive conditioning" techniques.

Side by side with this overt mistreatment, one finds the more insidious long term abuse of children left in the "limbo" of foster care or institutions with no hope of permanent placement, moved from foster home to foster home, to institutions, gradually being worn away, leaving what one teen-ager in San Francisco described as a "scar on my brain." I will leave it to others to describe these cases in graphic detail. Let me address here some of the systemic problems which underly this pattern of neglect, abuse, misplacement, and misdirected altruism.

First, the committee should understand that children who fall subject to child welfare and juvenile justice services are classified and labelled for the most part, dependent upon which governmental or quasi-governmental ("private" governmentally funded) agencies first enter the situation. It is not so much a matter of an objective or "scientific" diagnosis of the child's problem, nor indeed the legal definition of the problem which is crucial. Rather, it is the very response or non-response of whatever agency is involved which itself determines to a large degree, the label or diagnosis. Middle-class kids who are having problems tend to go the mental health or prep school route, and the labels follow from those experiences. Lower class kids tend to go the child-welfare or juvenile justice route, and the labels follow accordingly, particularly early on in the child's career as professional client. And we do need to think of the "clientizing" process as a process as much a creation of the professional child "helper" as it is indicative of a youngster's need for help. The problems youngsters have early on are very similar, be they later assigned to residential schools, reform schools, treatment centers or training schools. But once this process is motion, all sorts of other patterns come into play which muddy the waters and end up all too often subjecting the youngster to a system of "care" which destroys his or her chances for optimum life adjustment.

In this sense, though we have often been led to believe that we are dealing with issues of proper "child care" in our child care systems, tailoring our program responses to the needs of the youngster (be they institutional or non-institutional), in fact, the system could more accurately be described as a series of large bureaucracies which apply diagnoses and labels on the basis of bureaucratic needs rather than on the basis of any putative individualized needs of the children or adolescents themselves. For example, one of the major findings of the Center for Criminal Justice, Harvard Law School, in their study of uses of detention, was that a teen-aged offender tended to be kept in locked detention, not on the basis of the seriousness of the crime, or even on the basis of possible emotional instability. Rather, the major determinant as to whether a youngster was locked up or sent home, had to do with the number of vacant beds in the detention center on the night the youth was arrested. If there were cells, he was detained..If there weren't any, he was released. Similarly, youngsters who others might view as"psychotic", quickly become "character disorders" when they become management problems in the more posh state residential treatment facilities. The change in diagnosis of course dictates a shift in the quality of care...both related to bureaucratic and management needs, not to anything scientific or in fact "professional". It is out of this pattern that abuse and neglect of children in our care system originates. Perhaps the most glaring example of this is in the general and massive use of isolation rooms in the majority of our juvenile correctional and child care treatment facilities. The use of isolation is a management tool having nothing to do with care or treatment. Its debilitating effects are systematically ignored or rationalized. The final insanity of it is most obvious in its repeated use with adolescents who are considered "suicidal" . Virtually all the literature shows that a person is most likely to commit suicide in isolation, yet it becomes the prescription for the disturbed or suicidal youngster. Nowhere in the professional research can one find a therapeutic justification for prolonged use of isolation rooms. Yet, they remain in use in most state institutions in every state in the union, often blessed and validated by "helping" professional social workers and psychologists acting in their managerial roles. When there is little accountability, and when one has basically captive clientele, one can anticipate that those who are the objects of our concern will ultimately become the objects of our coercion. Such has been the history of child care in this country. Calling "the hole","intensive care" hardly alters the situation.

If I would have one bit of advice to the members of this subcommittee in their investigation of institutional child abuse, it would be to trust your "layman's" judgments and perceptions. By the same token, take the advice of child care "professionals" with a large grain of salt. I do not mean by this to denigrate professionalism in child care or to suggest that it is not necessary and important. It is needed and it is appropriate. HOwever, in this field the professional is not so easily separated from the bureaucrat, despite the MSW and PH.D. degrees. As a result, one is often dealing with bureaucratic problems which when called to accountability retreat behind the unassailable barrier of professional "expertise", thereby demanding immunity from the common sense judgments of the "layperson", be he or she businessman, a client or a senator. You should know that few have a right to claim expertise in this field, and that indeed if results were the measure, one could find little to justify most.

The system of child care which relates to institutionalized children is therefore basically an unaccountable and unresponsive arrangement. As a result, children are abused, misused, misplaced and forgotten to such a degree that it is more often the not the rule rather than the exception. And the irony is that virtually all of it is under a banner of care and concern. Having headed the major state child welfare or juvenile correctional agencies in three large states.(Massachusetts, Illinois, and Pennsylvania), I have seen little evidence of basic accountability in the system or indeed, for support of basic reform of the system by the major child welfare organizations. The perennial response to allegations of abuse and misuse, is that 1.)"we don't have enough funding" and 2.)"we need more 'qualified' staff." As desirable as both of these goals might be, the answer to the dilemma resides in neither of the abovementioned. With reference to funding, the institutionalization of children is already being much overfunded. It costs between $20,000 and $30,000 to keep a youngster in a state reform school per annum in most states. The Spofford detention home in New York City, with a reputation for conditions of neglect and abuse, costs in excess of $60,000 per annum per child. Most child welfare institutions who too often keep in their populations "lightweight" or comparatively malleable youngsters run in excess of $20,000 per child per year. The average cost of a state training school ("youth development center") in Pennsylvania is now approaching $35,000 per annum by the Pa. Dept of Public Welfare's own figures. This is more than the average upper-middle-class family could afford (the best eastern prep schools cost less than $8,000, room, board, and tuition). One might justify the exhorbitant costs if success were the rule, or if it was clear that the majority of youngsters could not profit from other less expensive forms of care, or indeed their families share in the glut of "service" expenditure. But such is not generally the case. Rather, we often spend 5 and 10 times the income of the "unfit" parents to place their children in institutions which guarantee further neglect and abuse. That money for the most part goes to a whole servicegiving establishment, thereby becoming more and more unavailable to the client as tax dollars become more scarce.

With reference to the second "remedy" proposed perenially...the need for more "qualified" staff. That too, is all too often a shibboleth. We need quality control of services. We need accountability. We need close monitoring. and we need advocacy for the children. If this can be given by "qualified" staff, so much the better. But qualifications in themselves guarantee practically nothing with regard to preventing child abuse in institutions. Some of the worst institutions for human neglect which I have seen, have been run by "qualified" staff.(e.g. the Juvenile Hall in Los Angeles) Some of the worst have also been run by "unqualified" staff (e.g. Rikers Island, Mountain View, Texas). Similarly, some of the best have been run by "professionals" and other fine programs have been run by "non-professionals". Perhaps the model should rest ultimately on some form of consumerism, whereby the professional or the "expert" is used as a resource, but the decisions are made by the "layman". Two comments come to mind...That of Harold Laski, the "professionals should be on tap, but not on top", or that of Aristotle, that the best judge of meal is not the chef, but the guest. Professionalism in itself is not a guarantee of decent care for youngsters.

The misuse of children in institutions in this country continues at a high and unacceptable rate. It is my impression that little has changed despite the rhetoric of reform, the hysteria surrounding "de-institutionalization, and the professionalization of 19th century ideology. Those who come forth as advocates for abused, neglected, over-institutionalized children should be looked at with the same measures applied in other arenas. The Child Welfare League of America, for instance, is one of the oldest and most respected lobbying groups for the needs of children. Having said this, Congress should also be aware that that organization derives the bulk of its dues from institutions and child care agencies with large institutional components. The needs of institutionalized youngsters may be no more consonant with the needs of these agencies, than the needs of General Motors directly reflect the needs of the average American. At times they may be similar, but they are hardly identical.

There is the matter of disincentives in the child care institutional field. There are virtually no incentives to move youngsters out of temporary foster care into adoptive homes for example. There are few if any incentives to work toward placing a youngster out of the institution into his or her own home. There are few incentives to work with the natural families. There are no incentives for residential centers to take those youngsters who are most in need of psychiatric or social services and who generally, as a result end up "warehoused" in large state hospitals or institutions for the retarded. On the contrary, the incentives are all in the opposite direction. It is to the advantage of the average institution to take the most malleable, least difficult youngster, least in need of "services" and to keep him or her as long as possible. This insures a steady per diem from the state or county, it moderates the number of unpleasantries which might occur in the institution or surrounding community if more difficult problems were accepted, and it also allows professional staff to deal with problem children which are totally unlike children in their own life experience. The result is often a dual system whereby those most in need are relegated to the large state warehouses for human neglect and those who could be more easily handled in non-institutional or family settings are kept on in the smaller, more intensive institutions, as inappropriate as it might be.

What can be done? What directions might lead out of the labyrinth? I would recommend a few things.

1. The witholding of federal funds from institutions which use isolation and "seclusion" rooms.
2. Witholding of federal funds from any institution which incarcerates in locked settings, any youngster who has not committed a crime.
3. Federal incentives to alternative programs as opposed to institutions.
4. A Moratorium on all federal monies for building of institutions, detention centers, etc.
5. Federal incentive support for monitoring and inspection of institutions by persons or agencies outside the inbred child welfare and juvenile correctional fields.

6. Movement toward consumerist models of evaluation of care. This might include the training of educated advocates in the evaluation of the adequacy of care being given by the child care professions.
7. Emphasis upon the development of small community-based youth service agencies.
8. Get adoption out of the hands of those agencies which derive their income from foster care or institutional reimbursement mechanisms.

Senator **RIEGLE**. Thank you for your views. I appreciate your testimony today.

I will be submitting questions for the record. There may also be other members of the committee who will be submitting questions to you for the record. I think this is the best way to proceed because I want to make certain everyone has a chance to testify.

Let me thank each of you on this panel for your contribution today. We will be submitting questions to you for the record.

Let me now call the next panel consisting of Sam Berman, executive director, Vista Del Mar Child Care Services, Los Angeles, Calif., on behalf of the Child Welfare League of America, Inc.; Norman Powell, vice president, National Organization of Child Care Workers Associations, Inc., New York, N.Y.

We will include your complete statements in the record. They will appear there for distribution to other members.

In the interest of time, I would ask you to try to give us a precise summary, if you would.

STATEMENT OF SAM BERMAN, EXECUTIVE DIRECTOR, VISTA DEL MAR CHILD CARE SERVICES, LOS ANGELES, CALIF., ON BEHALF OF THE CHILD WELFARE LEAGUE OF AMERICA, INC., AND NORMAN POWELL, VICE PRESIDENT, NATIONAL ORGANIZATION OF CHILD CARE WORKERS ASSOCIATIONS, INC., NEW YORK, N.Y.

Mr. **BERMAN**. I am Sam Berman, executive director of Vista Del Mar Child Care Services in Los Angeles, an accredited member of the Child Welfare League of America.

I am appearing today as a member of the board of Child Welfare League of America. We have some 400 accredited member agencies, providing a variety of services. Many of them are institutional programs. Our formal statement is provided for the record; I will summarize, as requested.

We require of our agencies standards above and beyond those of licensing. We agree with those who have spoken about the abuses in children's institutions and share their anger and indignation that such conditions do exist.

We would like to commend for your consideration several ways in which abuses can be prevented and be corrected.

First and foremost, I think there needs to be more recognition that we are speaking of different kinds of institutions. Some of the abuses that have been discussed fall in the area of proprietary agencies, such as, for example, the listing we just saw. Some exist in the area of public institutions, including primarily delinquency facilities and facilities for the retarded.

The league represents primarily nonprofit child welfare institutions although there are some public institutions as well.

One of the suggestions we have is that every agency should have an effective vigilant board of directors, a group of lay individuals who will see to it that policies and programs are in the interest of children and designed to assure their protection rather than permit any abuses.

The other has to do with the widespread implementation of standards of services that have been defined, that are available, and that can be enforced.

Each State has to develop a set of standards as guidelines for its licensing and has to enforce those licensing requirements.

Another approach that we believe would serve to protect children is the requirement of accreditation. Accrediting, by whatever route, can bring about the highest standards of service, can help assure that all the policies covered in the standards are maintained and there be regular monitoring of programs.

Many of these recommendations require on the part of the Federal Government a change in the legislative and administrative procedure, particularly as regards the role of the U.S. Children's Bureau.

I am in a sense ad-libbing from experience although our written testimony reflects these statements. Out of my concern that we find some way to prevent the horrors that have happened and that have been reported here today, I would rather not do it just from written material.

One of the services we need from the Children's Bureau is a return to the consultation and technical assistance they provided to the States in the past. This is particularly important in regard to the training, supervision, and licensing personnel, to make sure they do indeed enforce that which is on the books now.

We also believe that licensing standards must apply, although not licensing itself necessarily, to all publicly run agencies. Wherever children are, they should be given the same protection and the same safeguards regardless of auspices.

In California, and we believe it is a useful model for other States, we have developed a system of peer review. Child welfare agencies do not wish to have among their number agencies that permit abuses or poor practices.

We developed a system to certify for membership in our State association agencies that provide services. Probably the greatest possibility of enforcement of standards is through the purchasers or contractors for service. Each agency that provides service which receives any public money must enter into a governmental contract. That contract should call for standards that must be maintained, for procedures to be followed, that agencies are open to investigation and inspection, that monitoring be the responsibility of the county or State or whatever political subdivision is buying the service. And in particular we need a case review process to assure that no child comes into group care who need not be there and that no child remains in what we refer to as "institutional drift."

One of the most pressing needs is for the continuation and expansion of training, for the upgrading of personnel—from executive to child care staff, board members, whomever it may be, everyone associated with the care of someone else's children must receive responsible training to carry out those duties.

We urge methods of developing a range of services and, in particular, assistance to agencies to diversify their programs, rather than continuing to offer primarily, or in large part, group care.

Many agencies are changing their direction in order to provide the service needed by the child rather than by the service they happen to offer.

We do see the need for adequate funding as Senator Cranston's material itself indicated.

Under title IV-B we need help at least in terms of adoption subsidy now, so children can be moved appropriately out of group care. With full funding of title IV-B, much long-term group care can be avoided in the first place.

We like priorities that have been offered, and with regard to earlier testimony, I am personally in agreement with much of what has been said. But, I think the record needs to be clarified in some regard because there is some confusion.

In our anguish about problems, there is a concern about how public funds are being expended. Today there is a confusion about the use of public dollars for education of children as against child welfare services as such. In particular, mention was made of institutions operated by nonprofit organizations receiving funds for education of children and then using it for other purposes.

That cannot be the case.

Public Law 94-142 mandates educational opportunities for handicapped children, special education. It also mandates what is called mainstreaming, which is simply to get children into regular school systems as early as possible.

Mention was made of one agency with which I am familiar. The reason for my concern is that the executive director of that agency has been a child advocate for many years, an outstanding leader in the field. He is not without difficulties in his agency, I am sure, but his agency is one which offers quality care to children, which takes high risk children and provides services which should not be overlooked.

In respect to this or any other agency, we ask only that one's views of the agency not be limited in such a way as to condemn it out-of-hand without knowing all the background.

For example, as a California agency, it does file its audit reports and its form 990 including details about its endowment funds. It has a county contract which governs services it provides. It is a licensed agency.

It has gone through the peer review of our State. It is an accredited member of the League. It does have an investment portfolio as part of it assets because all voluntary nonprofit agencies must provide funding to help subsidize the provision of services. The agency—like any charitable group—will not decline donations of IBM or A.T. & T. stock, I can assure you. In fact, like other voluntary groups, they would welcome it. They need and use investment income in order to further the program.

The agency is accountable for those funds to United Way, to the county, to any contracting group.

A very good recommendation was made with regard to visitation by health personnel. There is the opportunity or should be the opportunity, I know there had been when I worked in the State of Illinois some years ago, for members of the State department of health to join with child welfare licensing representatives to make visits to agencies, announced or otherwise, for the purpose of licensing inspections. We would encourage that practice. It is a very good one.

If you have questions about the system of child welfare in terms of how it might be modified, in terms of legislation, I would be glad to respond.

I was pleased with the material given thus far about protecting the rights of institutionalized children, the opportunity for the defense of children's rights and staff rights in agencies, holding accountable all agencies that offer this service.

Senator RIEGLE. I appreciate your comments very much.

[The prepared statement of Mr. Berman follows:]

STATEMENT PRESENTED TO THE
SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT
HUMAN RESOURCES COMMITTEE
U.S. SENATE
BY
SAM BERMAN
EXECUTIVE DIRECTOR
VISTA DEL MAR CHILD CARE SERVICE
ON BEHALF OF
THE CHILD WELFARE LEAGUE OF AMERICA, INC.

JANUARY 24, 1979

The Child Welfare League thanks you for inviting us to testify and welcomes this opportunity to come before the Senate Subcommittee on Child and Human Development to discuss concerns regarding the abuse of children in institutions. My name is Sam Berman and I am Executive Director of the Vista Del Mar Child Care Service in Los Angeles. Vista Del Mar is a multi-service agency providing adoption services, foster family care, group homes, residential treatment, special services to children, and services to unmarried parents. Our agency is an accredited member of the Child Welfare League of America.

I am currently on the Board of Directors of the Child Welfare League, where I served as consultant, director of surveys, and then assistant executive director until 1973. I am a peer reviewer for the Council on Accreditation of services for Families and Children, Inc. I am a member and past president of the American Association for Children's Residential Centers; vice president, International Association of Workers for Maladjusted Children; and member, editorial board of The Child Care Quarterly.

I appear today on behalf of the Child Welfare League of America, (CWLA), Inc., which was established in 1920, and is a national voluntary organization for child welfare agencies in North America. It is a privately supported organization devoting its efforts completely to the improvement of care and services for children. There are nearly 400 child welfare agencies directly affiliated with the League, including representatives from all religious groups as well as non-sectarian public and private non-profit agencies.

The League's activities are diverse. They include the activities of the North American Center on Adoption; a specialized foster care training program; research; the Office of Regional, Provincial, and State Child Care Associations which represents more than 1,000 additional child and family serving agencies in this nation; the American Parents Committee which lobbies for children's interests; and the Hecht Institute for State Child Welfare Planning which provides information, analysis, and technical assistance to child welfare agencies on Title XX and other Federal funding sources for children's services.

We share and applaud your concerns about institutional abuse of children. Since 1920, the League has been playing a major role in the difficult but necessary job of trying to improve the care of children, both in and out of their homes. Accreditation and standard setting are perhaps our best known contributions. We are a membership organization composed of children's agencies throughout this country and Canada which have been accredited. We develop and revise standards for specific services to children and have done so for many years. We work with our agencies to help them meet these standards for services which nurture children and require regular reaccreditation through on-site review and evaluation.

The League also serves as an advocate for all children (not solely those served by member agencies of the child welfare system). Our advocacy began early in the 1920's when the League headed off a well-intentioned effort by the American Legion to establish large children's institutions in each State. Instead, CWLA worked with the American Legion to educate its leadership to the importance of strong public services, and it was the American Legion that proceeded to lobby for strong departments of public welfare. In the 30's and 40's it was the League's advocacy that was largely responsible for closing down the large "baby farms" and custodial public orphanages.

CWLA studies have helped to arm children's advocates with information to justify new directions in child welfare programs. Almost 20 years ago, one of our book-length project reports, "Children in Need of Parents" (Maas and Engler, 1959) revealed that children who stayed in foster care for 18 months to 2 years were rarely placed in permanent homes. The League recommended that new approaches in adoption be tried and encouraged the development of adoption exchanges on state and regional levels by setting up the first national adoption information exchange to link children with waiting families all over the country. To underscore those earlier findings, the League study, "A Second Chance for Families", (Jones, et. al., 1976) showed decisively that increased social services, which help people meet basic needs, have a demonstrable effect in reducing the need for foster care placement. CWLA has just committed itself to supporting a follow up study of "Second Chance," both because we want even harder evidence and because we want to increase professional pressure for needed preventive services.

In its role as a children's advocate, after other options have been tried, CWLA has turned to the courts and participated as an amicus curiae in numerous cases involving the resolution of harmful situations for children. For instance, in the late 60's, the League was an amicus in the landmark "man in the house" case that sought to deny benefits to children if there was a man living in the house, regardless of whether he was supporting the child or not. As an amicus in T.M. "Jim" Parham et. al. vs. J.L. and J.R. et. al., the League supports due process hearings before children are incarcerated in state mental institutions. In a current case before the Supreme Court, Youakim v. Miller, CWLA supports a policy that requires States to be responsible for AFDC foster care payments when a child is placed with a relative.

CWLA has been involved in international child advocacy and child welfare services activities from Biafra to Vietnam. We were among the few organizations to object when Vietnamese children from the postwar baby lift were not carefully screened to assure that they did not have parents or relatives and could legally be made available for adoption. Our adoption specialists have shared their techniques in finding permanent homes for hard to place children with many countries and similarly we have shared curriculum for training of foster parents. We have always been concerned with the appropriateness of certain child care arrangements. We are on record that all facilities, regardless of auspice, must be liscened or approved as meeting the same requirements of licensing. Licensing might have helped in respect to the alleged abuse of children in the People's Temple - however, ones does not need to travel to Guyana's jungles to find unlicensed facilities or horrors.

The Child Welfare League recognizes, as you do Senator, the overwhelming horror here in the United States. An incredible incidence of abuse is taking place in one segment of this country's institutions--juvenile jails and correctional facilities. During three days of discussions on the incarceration of children, televised live by public broadcasting from Washington last spring, children who had been incarcerated described the atrocities in certain public training school settings. Misuse of drugs, reliance on solitary confinement, and other cruel and unusual forms of punishment masquerading as "treatment" were common themes. As a moderator for the publicly televised discussions, the Child Welfare League's expert spoke to the special needs of certain violent, abusive and agressive children who are incarcerated. He also pointed out that sufficient resources and adequate, well trained, helping professionals are needed to provide necessary treatment for these children. The incarceration of children in large secure facilities which do not meet basic licensing of programmatic standards unquestionably leads to the abuse of children.

Our experience convinces us that there is a tragic incidence of abuse of our children in their own homes, an incidence far greater than in any type of child institution, regardless of auspice. In our judgement institutional abuse will not be curtailed until public opinion recognizes the explicit harmfulness of officially sanctioned corporal punishment (abuse) in the family. Increasingly, we are working with parents to help them end their abusive and neglectful patterns just as we are vigorously blowing the whistle on punitive or inadequate children's facilities.

As part of our campaign against child abuse, we frequently provide expert consultation to public and private agencies concerned with institutional care. Based upon research conducted by the League, and the experience of developing and enforcing standards, we have taken strong stands. Strongest of all of our recommendations is to create and maintain comprehensive, high quality child welfare services system in each State. This initially expensive recommendation has yet to be carried out by any State, as discovered in HEW's study of 25 States' child welfare systems. No State is a model, and some are disgraceful in their practice and their pennywise approach to their most valuable citizens.

The League has also conducted research and provided consultation specifically related to institutional care. In 1952, a CWLA study looked at the few residential treatment centers in the country. Our report, "Residential Treatment Centers for Emotionally Disturbed Children: A Descriptive Study" (Reid and Hagan, 1952) described actual operations and provided the background for continuing consultation to communities and agencies interested in improving their institutional care settings. Twenty-five years later, the League conducted another extensive study of group care, convened a major conference on the subject and published a document, "Group Care of Children Crossroads and Transitions," (Morris Fritz Mayer, et. al., 1977) addressing the comprehensive set of issues confronting the field with regard to improving the quality and effectiveness of group care.

Currently, the League's Research Department is completing the results of a survey of behavior management techniques used in Child Welfare League member agencies. This survey was conducted in the spring of 1978, at the request of League staff and member agencies with residential facilities. These agencies' staff were experiencing more difficulty in caring for children and wanted help!

As a result of the Federal goals to deinstitutionalize status offenders from correctional facilities, found in the Juvenile Justice and Delinquency Prevention Act and elsewhere, as well as other demographic and societal factors, child welfare workers have found themselves working with an increasingly older and more disturbed group of children in group care settings. The preliminary results of this survey of 144 group homes and congregrate care facilities of accredited Child Welfare League agencies focused on the use of medication and confinement as the two major approaches to controlling troubled children.

Use of Medication

Over half of the facilities surveyed did use medication as a method for handling children's behavior during the last five years. The predominant reason for use of medication was to alleviate the harmful behaviors of hyperactivity. Loss of impulse control, self abuse, and physical abuse of others were the other major behaviors which resulted in the use of medication. In the majority of facilities, the medication is usually prescribed by a psychiatrist employed by the facility or familiar with the child. The usual procedure for monitoring the use of medication includes close observation by child care staff, maintenance of written logs describing the child's behavior, and routine meetings with the pyschiatrist and the child care team. Authorized continuance or discontinuance of medication was based upon team meetings held periodically with the psychiatrist.

The major reason given for the increased use of medication was the increase in the number of disturbed children. The staff of agencies were generally dissatisfied with the dependence on medication to alleviate symptoms which cannot otherwise be controlled. Reasons given for not wanting to use medication included the concern that the drugs mask the actual symptoms and can become a crutch not only for the child but also for the staff. With an increase in more skilled staff, the use of medication decreased in some agencies.

In summary, the findings of the survey do indicate a significant use of medication, but do not seem to indicate abuse. The survey does represent the growing trend of agencies to participate in psychiatric drug therapy as part of their treatment program. The League, as well as the agencies surveyed, are concerned that dependency on drugs not be perpetuated. The use of medication by child welfare agencies must not substitute for adequate and well trained staff, and when used, be accompanied by strict safeguards and frequent professional monitoring.

Use of Secure Confinement

Twenty two percent of the facilities surveyed had confined children in a locked room or unit during the past five years. Secure confinement took various forms, including secure rooms attended by staff; locked rooms with one-way mirrors, and open, quiet rooms where staff are accessible outside. In most cases, procedures for monitoring children in confinement included a staff check every fifteen minutes plus a written log of the child's behavior. Usually, the child's confinement was limited to less than three hours, although reports of confinement longer than 24 hours were received. Over a third of the facilities required the authorization of the executive director or program administrator before confinement could be used.

The major reasons given for using secure confinement included, helping the child calm down and gain control and preventing the child from harming him/herself or others. The respondents to the survey recognized the disadvantages of using secure confinement as a means of punishment which can be psychologically harmful to children and may also be abused by staff.

As stated in the League's Standards for Services to Child Welfare Institutions, "When isolation is selected as the most advisable form of interference, it should be handled as isolation from a situation. It is essential for the child to have an adult nearby and in contact with him." (pgs. 45-46)

This survey on child welfare agencies' problems with controlling children's behavior has provided additional information for use by a national committee comprised of agency executives, program administrators and experts in group care which has been organized by the Child Welfare League. The committee will present proposed revisions to the current League standards on services of child welfare to the CWLA Board this year. Significant attention is being devoted to various kinds of good practices to be used by group care staff for control of children's behavior which will not only prevent physical abuse of children, but also will build or maintain the child's integrity, self-confidence, and self-reliance.

Standards Development and Accreditation

The League has had long years of experience in developing and enforcing high quality standards at the national and State level for all child welfare services. The League has actively advocated for and assisted States in developing strong, high quality programs and in developing licensing requirements and procedures to ensure appropriate services. This experience led us to initiate, with the Family Service Associatoin of America (FSAA) and with the support of HEW, the creation of the independent Council on Accreditation of Services for Families and Children. We were concerned that service standards have not been strengthened and frequently enforced at the Federal and State levels; therefore, we established this independent accrediting council to assume the function of accreditation of public and private agencies for which the League and FSAA have up to this time have been responsible. Many other major groups are now participating in the Council, and a major religious group, the National Conference of Catholic Charities, is exploring joint sponsorship with the League and FSAA.

Provisions for Accreditation provide guidance which can help to safeguard against abuse in instutional settings. These standards include establishing the responsibility of the agency's board and staff to implement procedures which result in accountable and appropriate services. The provisions also require the agencies to provide to its clients the opportunity and means to lodge complaints or appeals when decisions concerning them or the services provided them are considered unsatisfactory.

Two important areas of concern relating to abuse in child caring facilities, the misuse of medication and distructive use of discipline, have specific standards. The misuse of medication could be alleviated by adhering to the following provisions:

"MEDICATION OF CLIENTS, MEDICALLY PRESCRIBED DIETS, OR SPECIAL MEDICAL PROCEDURES ARE PROVIDED ONLY ON TIME-LIMITED WRITTEN ORDERS FROM A PHYSICAN.

- The agency explains and receives the consent of the client or client's guardian when medication, medically prescribed diets, or special medical procedures are part of care or service.
- A copy of the written order is maintained in the client's record, and medications are administered in accord with the written order.
- Agency policy specifies personnel authorized to administer medication.
- Administration of medications is logged, and their effects noted, in the client's record.
- The physician evaluates the client's response to medication, diet, or special medical procedures at the time designated on the written orders or sooner if indicated.
- All medications are labeled with the name and dosage of the medication, the name of the client for whom it is intended, the name of the prescribing physician, and a number or code identifying the written order.
- All medications are stored in a manner that ensures strict safeguards against unauthorized or accidental administration."

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With regard to discipline of children in group homes or child caring institutions, the provisions state:

> "Group Living is arranged to provide to every child the concern, care, protection, variety of growth experiences, and relationships normally expected for all children. Discipline is conducted in accordance with agency policy and the individual child's treatment plan that exclude: (emphasis added)
>
> - isolation in a special punishment facility for more than the time required for resumption of self-control and then only under the supervision of an adult;
> - degrading punishment
> - corporal punishment;
> - punitive work assignments;
> - group punishment for one child's behavior;
> - medication for punishment; and
> - the deprivation of the child's right and needs (e.g., food, parental visits)."

Additionally, the child caring agencies must assure that child care and supervision are continuously available, and that sufficient staff are assigned to provide adequate attention to the children at all times.

The Council on Accreditation currently has a Service Council on Residential Care Facilities that will evaluate public and private agencies that provide 24-hour residential care for children. The site review team includes trained professional field staff as well as peer reviewers--trained senior staff of agencies accredited by the Council. The review team looks into the governing body of the organization, finances, administration, the physical plan as well as the treatment program. Accreditation, which establishes good policies and practices provides a quality control mechanism for agencies to measure the delivery of services on the basis of standards. The League believes that accreditation, linked with adequate monitoring and licensing activities at the State level, are essential elements of an improved child welfare system, and improved residential care for children in particular.

We would like to submit for the hearing record copies of the CWLA Standards for Group Home Service for Children, and CWLA Standards for Services of Child Welfare Institutions, as well as the Council on Accreditation's Provisions for Accreditation.

The Role of Public Child Welfare Agencies and Citizens

A critical example of the importance of standards and licensing is reflected in the tragic death of foster children in Guyana and the current placement of over 200 children in the unlicensed Synanon camps. News reports of public worker caseloads of more than 100 children and their families clearly exemplify the case management problems of the foster care system in California. The lack of appropriate licensing activities to protect children in institutions, group settings, and foster home placement is also part of the problem.

Public agencies responsible for the care of children must have adequate staff not only for the casework services for the children and their families. They must also have adequate supervisory staff to assure the needs of the children are being met appropriately in the placement setting. There must also be effective monitoring and licensing staff to ensure the continued good care of the children. Arbitrary budgetary limitations and staff "freezes" are destructive to the maintenance of an effective public responsibility for the care of children. Adequate resources are necessary to maintain good care in both public and private agencies used to provide institutional care to children. Limitations, however well-meaning, do currently exist in California and other States and it will therefore be difficult to ensure that such tragedies will not continue to occur. If funds are short, and staff inadequate, who will question the "low bid" of the next "People's Temple" or review the care being provided to children?

We are aware of the increasing interest in the utilization of "citizen review mechanisms, not only for the purpose of evaluating the internal operation of institutions, but also for the broader purpose of reviewing the case plans of all children in various foster care settings. The establishment of an independent public agency or a group of concerned citizens to investigate children's institutions unless well organized and staffed by trained people, may indeed work at cross purposes with the already existing and important licensing units, placement units, and legally responsible protective services units of the public child welfare agency. However, experiments with independent foster care review boards, which will work in coordination with the State child welfare agencies and the family courts to review the disposition of all children in foster care placements, are now being conducted in various forms through State laws. Because of the interest in this approach, in four months, the League is sponsoring a major, specialized conference on various "Foster Care Review Systems". While exploring the issues involved with our funds, we also sought funding from HEW to do further research on the various approaches to foster care review.

The Importance of the Spectrum of Child Welfare Services

We wish to emphasize the important role of institutional care for children within the context of the entire spectrum of child welfare services. According to a recent HEW study, "National Study of Social Services to Children and Their Families", 28% of the children receiving services were in foster care facilities. Representing a total of more than 500,000 children, 79% were being cared for in foster homes, 14% in institutions, and 7% in group homes. While foster care services, along with adoptions, are often viewed as the child welfare services, there is indeed a broader array of services to children and their families which are essential for protecting and preserving the welfare of children. These services include supportive and preventive services such as protective services and emergency shelter care, homemaker services, social services for unmarried parents, day treatment, day care and social services for children in their own homes. Although this spectrum of services is generally acknowledged as necessary, resources in local communities are woefully inadequate to ensure the development and delivery of these services.

Currently, we see considerable attention drawn to the inadequacies of this child welfare system, with a focus on the lack of adequate case planning systems to ensure the development of permanancy for children, whether that be return to their own home, adoption, long term foster care, or emancipation. Concerns about over-reliance on the foster care system have also included concerns about the use of institutional care which is harming children. This committee has heard from several witnesses of the poor care and inappropriate treatment in some institutions, and an examination of this problem is warranted. However, this examination should not be based on the premise that institutions are bad and that institionalization of children, is of itself, abuse. All too often deinstitutionalization is seen as a solution for the tragic incidences of institutional abuse. Our experience with the care of children indicates that certain children need specialized, intensive and structured care available only in well-run institutions. When it is appropriate to place children in smaller facilities, it must not be seen as the less expensive way to go. Rather, the commitment of funds needed to develop and implement appropriate community based service facilities must be assured by all levels of government. The Child Welfare League of America believes that insitutions are a vital resource in the spectrum of services that a community needs to serve children who must be cared for outside of their own homes and who are more emotionally disturbed or violent. A comprehensive child welfare system is not comprehensive without group care facilities available.

The Federal Government's Role

A critical and important role is played by the Federal government in protecting the nation's most vulnerable and disturbed children. The child welfare system, established at the State and local levels, has certainly been enhanced through a variety of laws supported by this Subcommittee and Congress.

The income maintenance programs for dependent and disabled children of poor families; the Federal financing of foster care for children and the resultant regulations which call for an administrative six month review of children placed in foster care; and the historically important Title IV-B program of the Social Security Act, while under-funded, have provided a framework for the delivery of child welfare services in the States.

Likewise, the establishment of the National Center on Child Abuse and Neglect has helped focus national attention on the needs of abused and neglected children and the importance of services to their families or caretakers. The goals of the Juvenile Justice and Delinquency Prevention Act "to separate children from adults in correctional facilities and to eliminate the institutionalization of status offenders in correctional facilities" are important and should be pursued. Assurances that status offenders as well as juvenile delinquents will be appropriately served, according to their treatment needs, and in non-secure facilities, must be implemented through reasonable guidelines, however.

This subcommittee's leadership and strong support for adoption legislation has resulted in the enactment of a Federal program to locate permanent homes for hard to place children who are available for adoptoin. The subcommittee's diligence resulted in appropriations to support the program's early implementation. We and others are eagerly awaiting the Department of Health, Education, and Welfare's plan - more than six months after the bill's enactment - to implement the critical information exchange program which will match available children with waiting parents.

All of these Federal programs, strongly supported by this subcommittee, provide necessary resources and program requirements. However, additional funds and more stringent requirements and monitoring of the implementation for child welfare programs at the State and local levels are needed. At the Federal level, we believe that the major department responsible for the human services programs, Health, Education, and Welfare, should, through its existing oversight, monitoring, and auditing functions, make serious efforts to remedy abuses in service settings.

As a result of a General Accounting Office study of the foster care system and the resultant activities of the HEW audit agency, children in New York, through a recent State Supreme Court ruling, will be returned from out-of-state placements. The court's decision that foster care children have a constitutional right to treatment will finally set in action the review and return of children from placements in other States. The GAO and HEW studies, as well as the N.Y. Civil Liberties Union provided evidence of inappropriate care and treatment being provided by agencies in Florida, Virginia, New Jersey; in some cases provided by proprietary agencies.

We are also supportive of authority for the U.S. Attorney General to initiate or intervene in civil suits to protect the rights of institutionalized persons in cases of cruel or unusual punishment and lack of appropriate treatment as set forth in S. 10, the Rights of Institutionalized Persons bill, introduced by Senator Bayh. We are well aware of the lengthy time span and the large expenditure of funds which are required to implement enforcement procedures which will finally result in improved situations, but strongly believe that investigating and correcting abuses where they exist requires a stronger commitment from the Federal government.

The Child Welfare League continues to support the legislative efforts of Congress to improve the existing child welfare programs. As we see it, shortchanging these programs means settling for limited protections to limited numbers of children at risk of abuse and neglect. We support expanded funding for a stronger Title IV-B, mandated foster care review requirements, and Federal financial assistance for adoption subsidies for hard to place children, while maintaining the current open ended funding for necessary foster care.

The League stands ready to work with the Congress to see that child welfare legislation is enacted which protects children in need of services by providing adequate resources to support high quality services.

Summary

Comprehensive, high quality child welfare service programs in the States will only be achieved with adequate resources and enforcement of standards. Licensing and accreditation of agencies, coupled with strong public concern for appropriate care of children, will move us in the right direction. Throughout the past six decades of the Child Welfare League's existence, and the even longer time spent by child welfare agencies in working for and with children, we have witnessed frequent emotional events and dramatic headlines about the abuse of children. Protection and care do not make headlines, but they do stop abuses. We must continue to promote thoughtful and humane work with children and their families in an effort to prevent and alleviate harm to the nation's children.

Senator **Riegle**. Mr. Powell, you may proceed.

Mr. **Powell**. My name is Norman Powell. For the past 14 years I have worked as a child care work professional in institutions for emotionally disturbed children in the Washington-Maryland metropolitan area, and also in Latin America. Today I am representing the National Organization of Child Care Worker Associations.

Currently I hold the position of second vice president of the national organization. This organization was incorporated in 1977, and it is primarily an organization made up of direct line child care workers, and people who previously worked as direct line child care workers.

In a sense I am talking about, and we are representing those people, the child care personnel who actually work in institutions and actually have witnessed, and unfortunately, in some instances, have even participated in some of the abuses that we have been hearing about.

I would like to say a little more about our national group and how it got organized: On the State level a group of concerned child care workers got together and decided, that due to the great sense of frustration that they felt resulting from many institutional problems which they could not correct, it was felt that one way to advocate for children, but also attempt to better the situation, would be to organize an association on a statewide level.

Later we met in workshops and conferences with other child care workers from other States to discuss similar problems and who also expressed similar concerns. We decided that it would be a good idea to organize some kind of national group.

In terms of our view on the issue of institutional abuse, clearly there are many deplorable situations in institutions. However, we feel that if we closed down all the institutions and go to community-based kinds of programs or place children in foster care programs, this still is not going to resolve the problem of abuse because it is our belief that in order to work with emotionally disturbed, retarded kids, physically handicapped kids, it requires people with special skills and with special skills and with special expertise. Not anyone can work effectively with these special children. I do regret that there is not sufficient time for me to read my prepared oral statement.

Senator **Riegle**. We are going to put your prepared statement in the record at the conclusion of your testimony.

Mr. **Powell**. A main point that I want to make is that we vehemently disagree with the testimony that said more training of personnel would not rectify the problem. We vehemently disagree with that.

The child-care worker in an institutional setting is the person who spends the majority of time in direct work with the child. Fifty percent of the child-care workers in this country have less than a high school education.

For the child-care worker who is interested in gaining skills in child-care work, it is virtually impossible to get any college training, not to even mention graduate training, in the area of child-care work.

In the country there currently exists seven viable bachelor degree programs in child-care work. Because of this, one of the things that we would recommend would be Federal legislation that would require each State to certify child-care workers. Currently this is being done in only one State in this Nation, and that is New York; and this is being done through the New York Association of Child Care Workers.

The second point would be that child-care work training programs are urgently needed. They should be supported. Also, there should be support for local mental health organizations and training programs. Most importantly, there needs to be a commitment from local, State, and Federal authorities to support the priorities of the child-care worker.

As of December 20, 1978, the only program for the training of residential child-care workers on a national basis was canceled. This is indeed unfortunate for it represented the only federally supported effort to train those people who work directly with children in institutional settings. Thank you.

Senator RIEGLE. I want to be sure to incorporate into your written presentations any supplementary notes either of you develop that may have been missed in your summaries.

I appreciate your summarizing. I know the others who want to speak are also appreciative.

We may submit in writing questions from Senator Cranston and from myself and possibly others that will draw out some additional things that we would like to discuss with you.

Thank you very much.

Mr. POWELL. Thank you.

[The prepared statement of Mr. Powell and information referred to follows:]

STATEMENT OF
THE NATIONAL ORGANIZATION OF CHILD CARE WORKER ASSOCIATIONS, INC.
GIVEN TO THE U.S. SENATE SUB-COMMITTEE ON CHILD AND HUMAN DEVELOPMENT
WEDNESDAY JANUARY 23, 1979
CHAIR: SEN. ALAN CRANSTON (D.-CALIFORNIA)

My name is Norman W. Powell, Jr. For the past fourteen years I have worked as a child care work professional in institutions for emotionally disturbed children in the Washington-Maryland Metropolitan area. Currently I am president of the Maryland Association of Child Care Workers, Inc. and am here today representing the National Organization of Child Care Worker Associations, Inc. I currently serve in the capacity of 2nd Vice President of the National Organization. On behalf of the Board and Membership of NOCCWA, I would like to thank Sen. Alan Cranston and staff director Suzanne Martinez for giving NOCCWA the opportunity to offer this testimony relating to the institutional abuse and neglect of children. Such an opportunity has even greater significance in that this begins the first month of the International Year of the Child.

The National Organization of Child Care Worker Associations, Inc. was incorporated in the fall of 1977 and is composed of 15 state-wide associations of child care workers. NOCCWA is the only national group that represents the 100,000 child care workers who staff the residential facilities that care for approximately 300,000 children. The majority of these children reside in publicly supported programs, and are classified as emotionally disturbed, retarded, delinquent, physically handicapped, neglected and or abused. Child care workers, (sometimes referred to as houseparents, counselors, prefects, mental health aides, etc.) are those men and women who work directly with these youngsters attending to their basic growth and developmental needs over a 24 hour period. They are the "front line" workers who spend the majority of their working hours in direct contact with the youngsters and almost without exception are the institutional personnel who are the least prepared for their assigned responsibilities, receive the least remuneration, and have the least influence on the policies and decision making process of the institution.

This is indeed ironic, for it is the child care worker who by the very nature of his or her responsibilities is in a unique position in which to provide much support and advocacy on the behalf of the institutionalized children. Unfortunately, due to the lack of professional respect and administrative support, the child care worker works in a perpetual state of frustration, low morale, and anger. Thus, the institutionalized child rarely is benefitted by the optimum potential of this 24 hour direct care personnel.

The issue of institutional child abuse and neglect has been a perennial concern for competent and sensitive child care workers. It is unfortunate that it is only recently that this issue is being brought to the attention of the American public.

While it would be more comfortable for us to believe that the times of "Oliver Twist" are long gone, the unsettling reality is that there has been in the past, there is today, and there will be in the future considerable and extensive child abuse and neglect in our Nation's residential facilities unless quick and effective action is taken.

Numerous horror stories of helpless, defenseless youngsters victimized by both peers and staff can be recounted vividly by anyone who has worked for any length of time in a residential facility; or has had the opportunity to speak directly with child care staff or to youngsters served in such programs. The fact that many children are the victims of sexual assault by the adults to whose care they are entrusted; that harsh and abusive physical punishment is frequently inflicted; that living conditions both physical and emotional are often more deplorable than one would imagine; all of these facts are shocking, unfortunate realities; shocking perhaps to the vast number of Americans who have never really seen the inside of a children's institution. These truths are certainly most unfortunate for the youngsters who must live in these institutions, many through no fault of their own.

The National Organization of Child Care Worker Associations, through its network of nationwide contacts with child care workers in more than 25 states is in the unique position of having a wealth of knowledge of the conditions which exist in a multitude of institutional settings. At child care training conferences and workshops conducted in various parts of the country, incidents depicting abusive situations and conditions are openly verbalized by many of the child care workers who attend these conferences.

The depressing stories describing much of the physical, environmental, sexual, and emotional abuse existent in institutions where they have worked (or currently work) are recounted in the informal and formal discussions of the participants. During these discussions there are two recurring themes - 1) the pathetic lack of adequate training and supervision available to the workers and 2) the tremendous sense of frustration and helplessness felt by child care workers.

It is not surprising to receive these continuous reports of institutional physical and sexual abuse, when we consider the fact that the vast majority of agencies do little to effectively attract, recruit, and or retain qualified personnel. Today, in 1979 the minimum requirement needed to work in the majority of this nation's facilities for troubled children is an eighth grade education. Thus, we have a situation in which the least trained people are hired and given the direct care responsibility of the most disturbed and troubled institutionalized children. Prior experience with children is often preferred, but rarely a requirement for institutional employment.

In cases where an individual has been fired from one institution for incompetence, child abuse, or worse, he or she can easily find employment at other children's institutions for there literally are few enforced standards or effective checks. Undoubtedly, a great number of the adults who work in the nation's institutions as child care workers are competent, mature, well-trained professionals who are dedicated to providing the highest quality of care to the children with whom they have been entrusted. Nevertheless, while all states have developed clear and comprehensive guidelines for their "professional" staff positions, to our knowledge no state has established meaningful criteria for the institutional child care worker. In fact, the majority do not recognize the role as one of importance. When faced with this multitude of intolerable conditions, when met with constant frustration in their attempts to rectify or modify institutional abusive situations; coupled with sub-poverty salary scales and spartan-like work schedules, the majority of these competent and potentially competent individuals leave or are greatly tempted to leave this field for others that are more lucrative, less humiliating, and more professionally rewarding and recognized. This constant cycle of turn-over among institutional child care personnel creates an institutional milieu of continuous instability for all staff and children in residence.

Though rarely considered as such, the devasting psychological impact of this perpetual staff-turn-over represents one of the most flagrant examples of institutional emotional child abuse.

Institutional child abuse and neglect occurs in many forms. There are the more glaring and perhaps most serious forms of sexual abuse, certainly outlawed in every program, and usually occurring because of the inadequacies in screening, hiring and supervision indicated before. A somewhat less glaring form is physical abuse which occurs in far too many programs under various guises. Corporal punishment is one aspect of physical abuse which is not only permitted, but often encouraged in many programs throughout the country. Youngsters continue to be paddled, strapped, pinched, and otherwise, for comitting a range of institutional policy violations. Such activity often results in serious injury to the youngster, notwithstanding the sometime irreparable emotional trauma that occurs.

Yet another aspect of physical abuse is the often indiscriminate and irrational use of "Lock-up Rooms" and other restraining devices for youngsters under the label of "treatment". This is not to say that some disturbed and disruptive adolescents do not need to be restrained or temporarily isolated, however, sufficient number of child care staff, skilled in appropriate counselling and restraining techniques, would obviate the need for relying solely on physical restraints.

Yet another aspect of physical abuse is heavy use of psychotropic drugs and medications that predominate some programs. For the most part, this situation is not adequately monitored. Many child care workers have experienced seeing youngsters under their care so drugged that they had to be literally propped up. Because of the child care worker's low status in the program, and lack of training in human behavior, he lacks the ability to challenge or question this treatment modality.

Another form of abuse is Emotional abuse. More subtle than the other two, the effects of this abuse on children is just as devastating and long lasting. One of the things institutionalized youngsters need is a warm, secure enviornment, with sensitive, mature, and understanding adults providing consistent care. People who can help repair their damaged minds and guide them toward developing the necessary social skills for a productive life in society. To offer these youngsters less than competent caretakers, upon whom they must rely, is almost more damaging than leaving the youngsters in the environment from which they came.

The high turnover rate among child care workers adds to the emotional abuse of the institutional youngster. He, unfortunately is subject to a constant string of intruders in his life; and for each the child is asked to or expected to develop meaningful relationships.

That many workers, lacking even the most rudimentary skills in child care, unknowingly batter and abuse these children emotionally borders on being an understatement. It is ironic, that just one month ago (Dec. 20, 1978) HEW cancelled the only national training project for child care workers.

In many programs living groups of disturbed children are very large, with an inadequate number of child care workers to supervise them. This leads to many incidents where the youngsters in care are victimized. Likewise, many workers are left on duty with virtually no support or back-up systems to aid them in handling a difficult child. There have been countless incidents where uncontrollable youngsters have taken over the living unit and wrecked havoc on the other youngsters and the facility.

Poor programs and recreational resources add to the litany of incidents which leave too many of the more than a quarter of a million institutionalized children in doubtful living situations.

Environmental abuse is another element which preys heavily upon children who live away from home. Institutions with poor physical plants, inadequate living facilities and inappropriate locations can be found in almost every state. For example, one institution in a northern state housed 24 youngsters in a tight living area in double decker bunks. Although technically in compliance with the minimum state codes, the close quarters produce numerous problems among the youngsters.

Additionally, it hardly provided an atmosphere conducive to social growth and development. Beds, chairs and old metal lockers made up the furnishings, and as one child care worker remarked "How can you teach these youngsters care for their clothing when the agency does not provide dressers or clothes closets." Such problems in the provision of basic facilities is still a large problem among many institutional programs. Many facilities that house Black and Hispanic youngsters continue to deny them the opportunity of having culturally stimulating objects as a part of their living environment. The reality is that few programs recognize the importance of one's immediate living environment to one's development.

Unfortunately, many, many more examples could be added to each of the major categories of institutional abuse indicated here. It is a large and complex problem that highlights the fact that we as a society have not thought that children who live in institutions are really important. As the results of a three year national study of "Children Without Homes" conducted by the Children's Defense Fund pointed out; "Despite immense public concern about familial abuse, no state visited had set up mechanisms nor issued guidelines to monitor and eliminate the institutional abuse of children." Furthermore, "states are often neglectful parents - sometimes even abusive ones - failing to meet their ongoing obligation to individual children at risk of or in placement. Public systems lack the capacity to ensure coordinated program planning and service delivery. Compliance with even weak laws and regulations is inadequate."

The study goes on to point out that there is no explicit federal policy toward children living out of their homes; with the weakest area being the lack of federal protection afforded children at risk of removal, or already removed from their homes.

We believe that the Federal government must exert strong decisive leadership if the abuse of children in institutions is to be eliminated. This leadership must come, in part, through the development of a comprehensive policy directed toward setting the tone for quality care and treatment of institutionalized children. Appropriate legislation must be enacted and enforced, particularly in the area of national minimal standards. The approach must be comprehensive rather than piecemeal if the destructive patterns, currently too common, are to be reversed. Specifically, we would like to make the following recommendations to the Committee.

First, appropriate standards for children in institutions must be developed on a national level. These standards must include the entire array of services in an institution and specific provisions must address the role, responsibility, criteria, working conditions, and training for all child care workers. For example; training and educational programs for child care personnel must be developed on a large scale, in order to begin the process of developing a pool of qualified workers who can staff institutional programs. It should be noted that in Sweden, France, Canada and other countries, there is a government certified and recognized individual called an Educateur or psycho-educateur, who handles duties similar to those of the American child care worker. These individuals are trained in nationally recognized programs, similar to teachers and social workers, and then are licensed by the state. This professional cadre of men and women, who likewise receive professional salaries, provides a much higher level of care to children in institutions than currently available to American youngsters.

A National Training Plan should be developed that would insure immediate in-service training and staff development programs aimed at up-grading the skills of child care workers currently employed. Concurrently, such a plan should include the professional development of the child care worker role, culminating in a nationally recognized certificate as an indication of minimal competency for child care practice. It is incrediable when we consider the fact that there are only seven colleges in the entire country that offer BA level degrees in professional child care.

Comprehensive standards should also address such areas as recruitment and hiring policies of agencies, ratio of child care workers to children, references and screening procedures, physical facilities and furnishings (particularly in the child's living area) and internal and external grievance procedures for children and staff.

Another area requiring major attention is the salary scales for child care workers. Salary scales must be sufficiently raised in order to attract the most qualified workers who will stay longer and avail themselves of the necessary training. Currently, in many parts of the country, child care workers are paid considerably lower than teachers or social workers. In some areas they are paid lower than maintenance personnel in the local municipality. In some cases the wages of some child care workers are just above the poverty level. In almost every institutional program, the child care worker is the lowest paid staff member involved in "treatment" - yet always the one whose interaction with the youngster is the most constant and demanding, physically as well as emotionally. Rectifying this situation does not necessarily mean putting more money into the system, but rather re-ordering Federal, state, and local funding patterns and agency priorities to free up resources for more realistic child care salaries.

While child care workers will always be subject to odd working hours, weekend duty, and shift work, working conditions and other benefits need to compensate for these necessary but unusual working conditions.

There also needs to be built-in systems that provide for a more careful monitoring and review of institutional programs. These systems should be both internal and external to the institution, and should provide the mechanism to enable child care workers and other staff to advocate for children. While such systems may seem threatening to some, its careful development and implementation can only serve to strengthen our ability to provide better services to children.

We have confined our recommendations to those most significant to child abuse and neglect in institutions and the child care worker. Because of our limited resources and having only recently been invited to respond to this hearing, we did not have the time to prepare a more comprehensive response. We would, of course, welcome the opportunity to expound on and further define our recommendations.

Thank you for extending to us this time.

Senator RIEGLE. Let me ask Mr. Barr, Mr. Smiles, Dr. Kline, and Mr. Aber to come forward.

I understand Senator Hatch wants to introduce Dr. Kline.

Senator Hatch, we are pleased to have you here.

Senator HATCH. Thank you very much, Senator.

It is a great pleasure and honor today to introduce to the Subcommittee on Child Abuse and Neglect a fellow Utahan and one of our Nation's most eminent experts in the field of child abuse, Dr. Donald Kline. Dr. Kline is one of the pioneers in the battle against child abuse and neglect. He is head of our State's Department of Special Education and is the author of several of the major articles and research projects in the field.

I am particularly honored to be able to present Dr. Kline to this subcommittee because he is one of the primary advocates of increased efforts to prevent this terrible tragedy of child abuse. I believe his views on needed reforms of residential institutional practices deserve a wide hearing, and I am glad to note that the National Center for Child Abuse and Neglect has awarded a research contract to the Utah State University team which Dr. Kline personally trained.

So I commend to the subcommittee, the committee upon which I also sit, Dr. Donald Kline and, of course, I am sure these other gentlemen who are with him here today.

It has been a privilege being here, Doctor. I have to run, but I wanted to just let Senator Riegle and Senator Cranston and the other members of our committee know of your achievements and my own confidence in those achievements.

Senator RIEGLE. Thank you, Senator Hatch. We're grateful that you could appear here this morning and introduce your distinguished colleague from Utah, Dr. Kline.

We will start with Dr. Kline first and then we will go on to the others.

STATEMENT OF WILLIAM W. BARR, ADMINISTRATOR, SOCIAL REHABILITATION ADMINISTRATION, DEPARTMENT OF HUMAN RESOURCES, DISTRICT OF COLUMBIA, ACCOMPANIED BY GREGORY SMILES, PROJECT DIRECTOR ON INSTITUTIONAL CHILD ABUSE, DIVISION OF YOUTH AND FAMILY SERVICES, DEPARTMENT OF HUMAN SERVICES, STATE OF NEW JERSEY; DONALD KLINE, PH. D., DEPARTMENT OF SPECIAL EDUCATION, UTAH STATE UNIVERSITY, LOGAN, UTAH; AND LARRY ABER, SPECIAL ASSISTANT TO THE DIRECTOR, CHILD ABUSE UNIT, OFFICE FOR CHILDREN, COMMONWEALTH OF MASSACHUSETTS

Dr. KLINE. Thank you, Senator. I am honored by that introduction.

At the outset, let me set the record straight on one item. We heard a moment ago that all of the grants for institutional abuse and neglect have been given to State agencies who are responsible for the operations of the institutions. In a technical sense, I suppose that is true. In a literal sense, at least, Utah is an exception.

While our State Division of Family Services was the technical recipient of the grant, we have a statute in our state that prohibits the agency from examining cases of child abuse or neglect within the institutions that operate under its aegis. They have, therefore, subcontracted this project to our Child Abuse Study Team at Utah State University, and we are very pleased to be working in that capacity.

The relationship between our university-based team and the Division of Family Services. It is a little bit like being a hearing officer for a public school under Public Law 94–142. While the public school is charged with paying for the services of that officer, the Federal rules and regulations say they are not within the employ of the public school and, therefore, they do not have a conflict of interest.

Frankly, I want to say as a matter of record that while we are subcontractors to the Division of Family Services, we are not in their employ and, therefore, we do not represent a conflict of interest in investigating child abuse and neglect in our own institutions in Utah.

Second, Mr. Chairman, I would like to extend an apology for not entering a lengthy statement for the benefit of the record. The reason for that is, of course, that we had very little leadtime. Frankly, I have summarized to a large extent those comments that I want to say to the committee and for the record. At the same time, I would offer to produce additional evidence and written testimony, should the committee so desire.

Let me skip quickly to some of the statements and make them quite categorical. If there are questions, I will be happy to respond.

First, I was particularly pleased when Senator Cranston indicated at the beginning of this hearing today that until now we had failed to look systematically at the problems of institutional abuse of neglected children. I think that can be substantiated. At the same time, I would not detract or detour or minimize the work that has been done by Ken Wooden, Mr. Miller, the Justice Department, and others.

In the interest of clarity and hopefully of brevity, let me make the following comments.

While we hear stories about the atrocities that go on within our institution, and I know they do, I think the committee should know that the children who come into conflict with the law and ultimately populate our institutions are for the most part victims of physical abuse, neglect, abandonment, and/or sexual molestation before they come in conflict with juvenile authorities and before they are committed to institutional environments.

Senator **Riegle**. Dr. Kline, I'd like to interrupt for a moment please. I must leave for a short period, but I hope to get back here. I have another matter which I must attend to and I cannot postpone it. I am going to ask our staff counsel, Susanne Martinez, to chair the hearing while I am away, and I would like to proceed in order until either we finish or I am able to return.

Please continue now, Dr. Kline.

Dr. **Kline**. May I now say, Ms. Chairperson, second, too many of those employed by our institutions are untrained or inadequately trained to cope with the complex social, psychological, and educational problems these children bring with them to the institutions where they are committed.

This is not to say that the institutional psychiatrist or physician is inadequately trained. But the large part of a child's day is spent in his cottage, in his cell, whatever it happens to be. And, in our part of the country, these people charged with their supervision come from the community in which the institution is located. By and large, they have not had any special training in working with these children.

Third, I would like to observe that most of the American public still cling to the notion that children placed in institutions are inherently bad, inherently angry, and inherently committed to socially unacceptable behavior, and that society is entitled to extract retribution for their wrongful acts.

There is an abundance of testimony to show that most of these children are not criminals. They may be status offenders, runaways, and the like, but they are not criminals.

I would submit to the committee and for the benefit of the record that at the juvenile level, when you find a status offender, he/she is probably running for a good reason.

I think the American public is becoming more aware of the cause of child abuse and neglect. Still a large majority of us fail to realize that both the abusing parent and the abusing institution have minimal knowledge of child growth and development, and a strong belief in physical punishment as a form of discipline. I would remind all of us that punishment is a retribution for wrongful acts. Discipline comes from the word "disciple." They are two quite different connotations.

Third, abusing caretakers have little empathy for the needs of children. There is an expectation from many of the children who are born to abusing parents, through no fault of their own, that the child should provide the love and comfort for the adult, an expectation that we have come to identify in the literature as "role reversal."

Next, an examination of the children in institutional settings show that they are substantially substandard from an intellectual perspective and most have a specific learning disability. It should be noted here that even in those institutions that care for the mentally retarded and developmentally disabled, the majority of the residents are environmentally retarded rather than retarded because of organic causes.

Among adjudged abused and neglected children in my State, 27 percent are enrolled in special education classes for the retarded, emotionally disturbed, or learning disabled and they are not in residential institutions. Anyone familiar with the incidence data regarding children who need special education know that about 12 percent of non-identified abused children are in need of these services.

Of the children in Utah who experienced sexual molestation or exploitation, approximately 46 percent are described by their teachers and other school personnel as "hostile"; 22 percent of the neglected children are described as "having poor social relationships"; and 17 percent are described as "destructive, absent from school, aggressive or exhibiting stealing behaviors": and 21 percent of those children who were physically abused are described as being "destructive and aggressive."

I submit it is no wonder that these children ultimately come in conflict with juvenile authorities and ultimately find their way into our institutions.

In one study of the children who were known to the juvenile authorities in the city of Los Angeles, 50 percent subsequently had adult criminal records.

So far, Madam Chairman, I have simply enumerated the characteristics of abusing parents and abusing institutions. All of what I have said can be substantiated by empirical research data. And while the percentages may change from State to State or institution to institution, the basic pattern will remain relatively unchanged. It is a pattern upon which this committee and the Congress may rely.

The critical question which this committee must ask is, "What can be done? What legislation can we enact that will alleviate the problem?"

Turning again to the literature we find that certain biological and psychological characteristics are much more prevalent in abused children prior to the abuse than in nonabused children.

Let me illustrate. A retarded child, for example, who fails to live up to expectations of his parents, whether it is biological parent or foster parent, a parent who has adopted the child, failing to live up to those normal expectations invites more abuse than the nonretarded child. The same thing is true of children who are disabled, who may have emotional disturbances. We talk about being minimally brain-damaged and the like.

These characteristics include natal prematurity, mental retardation, physical handicaps, and observed behavioral aberrations. Interestingly, these same characteristics tend to distinguish institutionalized children from noninstitutionalized children. Thus, in the institutional setting we are gathering together groups of children who have already demonstrated a high likelihood of being abused. In fact, the empirical data supporting my earlier statement clearly demonstrates that nearly 68 percent of the children at the Utah State Development Center, a new name for our reform school, and 98 out of 115 or 81 percent of the children at the Idaho State Training School were physically abused, neglected, or sexually molested or exploited prior to their commitment to these institutions. In addition, we find the employees of institutions are, for the most part, untrained or inadequately trained because they come from indigenous population of rural communities.

Based on my experience and upon the available literature I make the following recommendations as alternatives to our present practices.

One: Deinstitutionalization: The expansion and improvement of the foster care programs as a means of dispersing the high-risk children.

Let me insert parenthetically that I did not use the term foster parent programs. I am talking about foster care programs. By no stretch of the imagination should a placement in a home environment be considered a foster parent until that individual has legally adopted and assumed the full responsibility for that child in his care.

This may mean a substantial increase in the rates we pay for foster care. At the same time it will mean a reduction in the amounts spent for keeping the child in an institution. At the present time in Utah we are spending $56 per child per day for institititionalization, or $20,440 per year. The highest rate for foster care in our State—for specialized foster care—is $13.24 per child per day or $4,713.44 per year. If the difference of $15,726.56 were spent for training and community support services the likelihood of rehabilitation would increase significantly.

Two: When we gather the high-risk children and youth together in institutional settings, we must assume that there will be abuse, not by the staff alone, but peer abuse. The children and youth in institutions have, for the most part, learned abusive behaviors from the significant adults in their lives and it is a normal part of their response to crisis situations.

And, as noted earlier, we need more training. In far too many instances, there are no policies designed to deal with abuse that results from crisis situations, in institutions. Certainly there is a dearth of monitoring from agencies, institutions, or laymen, from outside the system.

Support services for employees in institutions are greatly needed. Also, it is important that the array of support services required by specialized foster care personnel be provided. These support services must become a part of the environment for staff as well as for the children.

Time constraints prohibit full discussion, Madam Chairman, of what we learned about institutional abuse and neglect. But it has already been exposed well to the committee this morning.

We have many miles to travel, before we have empirical data as opposed to clinical data and observations that have already been made that will tell us how to deal more effectively with the problem.

In concluding, I want to say two things. The grant which we in Utah received to study institutional abuse and neglect is roughly equivalent to the amount it takes us to maintain four children in an institutional environment in 1 year. I think if we extend the amounts of money that we have been able to spend for all four of the grants designed to study institutional abuse and neglect, we can safely say that it is roughly equivalent to the cost of maintaining about 16 children in institutional environment for 1 year's time, a very small price to pay for the first four research and demonstration projects that are currently underway.

Finally, in concluding my testimony, I think it is important to note that when we examined the records of our Utah State Penitentiary, 709 of the 851 or 83 percent of the male inmates, and 26 of the 35 female inmates of the Utah State Prison were under the age of 19 when they first came into conflict and were arrested by the law.

Madam Chairman, if we are to make any progress in reducing these figures, we must have support for research. We must have support for experimentation and demonstration.

We must have support for community-based services, for families who abuse and neglect their children prior to their being picked up by juvenile authorities and placed in institutions.

Finally, I must submit we must teach all American youth about appropriate parenting behaviors prior to parenthood.

Thank you, Madam Chairman.

If I can answer any questions or if I can be of any service to this committee, please afford me that privilege.

[The prepared statement of Dr. Kline follows:]

Testimony Regarding Institutional Abuse and Neglect
Senate Sub-Committee on Child and Human Development

Testimony by

Donald F. Kline, Ph.D.
Professor and Head
Department of Special Education
Utah State University
Logan, Utah 84322

Mr. Chairman, Members of the Committee:

For those of us who have been working in the field of child abuse and neglect, please permit me to express our appreciation to you and members of your committee for holding this hearing. This hearing on institutional abuse and neglect of children and youth is, in the opinion of many of us, long overdue.

History records that we have made substantial gains in providing for the indigent, for those who are poor, for those who require rehabilitation because of accidental injury and in our efforts to eliminate discrimination. Unfortunately, until now, we have not concerned ourselves too greatly with the problems of children who, through no fault of their own, were born to parents who have little or no knowledge of child growth and development, who hold a strong belief in the use of physical punishment as a form of discipline, who have no empathy for the needs of their children, and who expect that giving birth to a child will provide them with the love, comfort, and concern which they never received either as a child or as an adult.

Only recently have we concerned ourselves with an educational system that systematically excluded the mentally retarded and other developmentally disabled children. And, until now, we have failed to look systematically at the problems of institutional abuse and neglect of children and youth.

In the interest of time and hopefully of some clarity, please permit me to make a few categorical statements that are based on empirical evidence.

1. The children who come into conflict with the law and ultimately populate our institutions are for the most part victims of physical abuse, neglect, abandonment, and/or sexual molestation before they come in conflict with juvenile authorities and before they are committed to institutional environments.
2. Too many of those employed by our institutions are untrained or inadequately trained to cope with the complex social, psychological, and educational problems these children bring with them to the institution where they are committed.
3. Most of the American public still cling to the notion that children placed in institutions are inherently bad, inherently angry, inherently committed to socially unacceptable behavior and that society is entitled to extract retribution for their wrongful acts.

4. While the American public is beginning to become more and more aware of the causes of child abuse and neglect, still the large majority fail to recognize that both the abusing parent and the abusing institution have (a) minimal knowledge about child growth and development, (b) a strong belief in the use of physical punishment as a form of discipline, (c) little or no empathy for children's needs, and (d) an expectation that the child should provide love and comfort for the adult -- an expectation which is identified in the literature as "role reversal."
5. An examination of the children in institutional settings show that they are substantially substandard from an intellectual perspective and most have a specific learning disability. (It should be noted here that even in those institutions that care for the mentally retarded and developmentally disabled, the majority of the residents are environmentally retarded rather than retarded because of organic causes.)
6. Among adjudged abused and neglected children in my State, 27% are enrolled in special education classes for the retarded, emotionally disturbed, or learning disabled even though they are not in residential institutions. Anyone familiar with the incidence data regarding children who need special education know that about 12% are in need of these services.

7. Of the children in Utah who experienced sexual molestation or exploitation, approximately 46% are described by their teachers and other school personnel as "hostile"; 22% of the neglected children are described as "having poor social relationships"; and 17% are described as "destructive, absent from school, aggressive or exhibiting stealing behaviors"; and 21% of those children who were physically abused are described as being "destructive and aggressive."
8. In one study of the children who were known to the juvenile authorities in the City of Los Angeles, 50% subsequently had adult criminal records.

So far, Mr. Chairman, I have simply enumerated the characterstics of abusing parents and abusing institutions. All of what I have said can be substantiated by empirical research data. And, while the percentages may change from state to state or institution to institution, the basic pattern will remain relatively unchanged. It is a pattern upon which this Committee and the Congress may rely.

The critical question which this Committee must ask is, "What can be done? What legislation can we enact that will alleviate the problem? "

Turning again to the literature we find that certain biological and psychological characteristics are much more prevelant in abused children prior to the abuse than in nonabused children. These characteristics include natal prematurity, mental retardation, physical handicaps, and observed behavioral aberations. Interestingly, these same characteristics tend to distinguish institutionalized children from non-institutionalized children. Thus, in the institutional setting we are gathering together groups of children who have already demonstrated a high liklihood of being abused. In fact, the emperical data supporting my earlier statement clearly demonstrates that nearly 68% of the children at the Utah State Development Center and 98 out of 115 or 81% of the children at the Idaho State Training School were physically abused, neglected, or sexually molested or exploited prior to their committment to these institutions. In addition, we find the employees of institutions are, for the most part, untrained or inadequately trained to deal with these special children, highly at risk for abuse.

Based on my experience and upon the available literature I make the following recommendations as alternatives to our present practices.

1. Deinstitutionalization: The expansion and improvement of the foster care programs as a means of dispersing the high-risk children. This means a substantial increase in the rates paid for foster care. At the same time it will mean a reduction in the amounts spent for keeping the child in an institution. At the present time we are spending $56.00 per child per day for institutionalization or $20,440.00 per year. The highest rate for foster care - for specialized foster care-is $13.24 per child per day or $4,713.44 per year. If the difference of $15,726.56 were spent for traininining and community support services the likelihood of re-

habilitation would increase significantly.

2. When we gather the high-risk children and youth together in institutional settings we must assume that there will be abuse not by the staff alone but peer abuse. The children and youth in institutions have, for the most part, learned abusive behaviors from the significant adults in their lives and it is a normal part of their response to crisis situations. And, as noted earlier, employees of the institution are untrained or inadequately trained to deal with abuse and in far too many instances there are no policies designed to deal with abuse that results from crisis situations. Screening to insure that staff members have the necessary skills and understandings to deal with frustration and ambiguity, understand the abused and neglected child and his characteristics and how to deal effectively with these children and situations is not only possible but critical to the solution of institutional abuse and neglect of children. For those already a part of the system, training, counseling, and workable policies and procedures must be developed, used, and monitored.
3. Support services for those already employeed in institutional settings is as important as the array of support services required by specialized foster care personnel. These support services must become a part of the environment for staff as well as for the children and youth involved.

Mr. Chairman, time constraints prohibits a full discussion of what we know and are learning about institutional abuse and neglect. We have many miles to travel before we will have the empirical data needed to determine how effective we may be in solving the problems. In concluding this testimony, however, I feel it is important to remind you and your committee that 709 of the 851 or 83% of the male inmates and 26 of the 35 female inmates at the Utah State Prison were under the age of 19 at the time of their first arrest.

Mr. Chairman, if we are to make any progress in reducing these figures we must have support for research, we must have support for experimentation and demonstration, and we must have support for community based services for families who abuse and neglect their children, and we must begin to teach all American youth about appropriate parenting behaviors prior to parenthood.

Thank you Mr. Chairman. If I can answer any questions or be of any service to this committee please afford me that priviledge.

Ms. **Martinez**. Mr. Barr.

Mr. **Barr**. I am William W. Barr, Administrator of the Social Rehabilitation Administration of the Department of Human Resources, District of Columbia Government.

I have at my side, Madame Chairperson, Sharon Harrell, who is project director of one of the HEW-funded projects you heard discussed this morning.

I will depart in a summary way from my prepared statement which you already have to simply say a few things regarding what I feel about the issue of maltreatment in institutions and how I have come to my viewpoint.

Very quickly, my work experience is very much related to what you heard today. I was a police officer at one point, a juvenile probation officer later, subsequently an institutional caseworker, and then was promoted to Administrator. I was promoted to Deputy Director of the old Department of Welfare wherein I became responsible for shelter care, the detention program, and for the development of a prevention program. In the last 5 years, the present responsibility I have entails the foster care program, child abuse, adoptions, protection of adults and programs for the handicapped and disabled.

So, very much of what I feel now about these issues is based on those kinds of saddles I have worn. I am not an expert, but I think this is the proper forum for me to be in today.

I have had the most interesting experience staying in this city about 22 years watching a wide range of people come before forums like this—and other kinds of professional conferences and community groups—to discuss the issue of the care of children.

Now I am glad I stayed here. I used to want to go to the great State of California or Utah and work in the Youth Authority, but I am sort of glad I stayed because I have had the chance to see many viewpoints expressed in different settings where a person speaks one way officially about this issue, another way before the press, and another way over cocktails at someone's retirement party, and another way entirely different somewhere else. I have come to understand those people who say the same thing all the time, that this is a water glass, and it is never a crystal ball. The issue remains the same, no matter which setting I catch them in. I have learned to appreciate them very much.

It has caused me to think we have to avoid, as we deal with these issues at this time, taking on the messiah complex. I really have come to have a problem with some of us. I am not speaking about any one of us but anyone who keeps up with the issues can make his own decision about that. I question the unilateral action of persons who for some reason, come into a position of responsibility anywhere in the system, public or private, and develop with the use of that power a thrust that, in my opinion, should be more reduced to the referendum of this country for people to make decisions about how we handle our children. I think it would be arrogant beyond belief for me to take my position, for example, and thrust on this city my notions and my ideas and try to drive them in the direction that I think they should go about rearing their children. I think that is the basic issue and that institutions are part of a child-rearing system.

Child-rearing practices are expressed by judges in court orders, psychiatrists do it in evaluations, or we do it in some decisionmaking in the executive branch. A policeman does it in terms of whether he arrests or does not arrest. I think it is too great an issue for a handful of people out of 220 million Americans to clamp their own ideas on this Nation without a thorough "going back to the grass roots."

I always have a problem in testimony as I watch it at different places where I have been when it is asserted that "the public" is testifying. I find out that "the public" are the city and municipal people with vested interests. I am not knocking their right to be there. I just want the public to be there. I want to know what the mothers have to say to me. They taught me in my career and gave me more understanding of our institutions. The mothers taught me what they feel about our services. I do not want to represent a special viewpoint. I have to tell everybody I am Bill Barr, and I come from Human Resources. You read about me in the paper all the time. You understand I am "Bill Barr, professional," and "Bill Barr, something else."

The problem I have had personally in this city is the vast number of children who come through who, for some reason, like the institutions' setting. I guess that is a shortcoming of mine. I have long said to our staff that our problem is to make children physically comfortable and not psychologically comfortable. It is a very difficult task. When I was superintendent at Cedar Knoll, I thought it was tough. The children thought it was a playground. That is the dilemma. I was in there with a specific assignment to turn it around from custodial orientation to more treatment orientation. So I am perplexed. It is the reason why I believe we need more viewpoints on a given day as we begin to develop Federal thrusts in this field.

I do think there ought to be a mechanism to develop a unified thrust in Government as we make improvements in institutional care. I do not know who has the leadership role. I am never sure whether it is the executive branch, judicial branch, or legislative branch.

I remember some of us from the District government, testifying before a congressional committee, making reference to a court order in our budget justification and being told that "no court was going to order the committee to appropriate money." In addition, we in the executive branch have been directed for several years to reduce the budget while the judicial branch has produced a field of court-ordered law that calls for expansion of budgetary resources to meet decent standards of care in institutions or/and to deinstitutionalize.

Congressman Riegle (now Senator Riegle and a member of the Senate Committee on Human Resources) told the Director of the District of Columbia Department of Public Welfare in February 1970, during budget hearings being conducted by Chairman William Natcher in the House, that he was concerned—along with his colleagues on the committee—about the amazing growth of appropriated positions in the District government. He was among many legislators who expressed concern about the growth of Government in the 1960's and who stated that it could not continue to balloon. The 1970's has been drastic reduction of Government resources in the District of Columbia even as advocates have mounted class action suits to improve services. Legislators have been listening to the complaints of taxpayers long before proposition 13 made California history.

The issue of funding is tricky. One cannot assure the committee that expenditures of more money will greatly reduce child abuse in institutions, just as vast expenditures of money on domestic programs in the 1960's did not prevent the urban upheavals from occurring near the end of the decade. But I will say this: If we do not properly fund these facilities, if we do not properly staff them; we are going to have a greater problem because we are depending on the quality of interpersonal relationship in child care. This impacts on the degree of child abuse in institutions.

I have another recommendation related to the role of Government. I believe that a trend took place over the past 40 years in which the Government—assisted by the helping professions—interposed itself between parents and their children by going too far in assuming parental responsibility. We relied too heavily on institutional placement or foster care as being "better than the home." I believe too many parents readily yielded up their parental rights and responsibilities to the "Government." It is a phenomenon described in part by Peter Drucker in his book "The Age of Discontinuity" specifically in the chapter entitled "The Sickness of Government." We in the Government inadvertently took away the feeling of parental responsibility even as we talked about "teaching parenting." We became the parents—and I do not believe the Government can "raise children." Communities and neighborhoods have to raise children—not the Government—even though Government funding is used in certain programs. We should begin to reverse the trend and return the responsibility—the sense of parental responsibility—to families, neighborhoods, communities.

One last recommendation I will make before I ask Ms. Harrell briefly to tell you about the project for the sake of your interest here.

We need to strengthen some institutions, I hope in this movement. I am not here to defend or not defend shutting down institutions, that is a decision that ought to come in that process. I can work either way myself. I have worked both ways. It is not something in which I have a vested interest.

If you do not have a complete reform move going on at the same time, please do not starve the institutions and leave us with a population of youngsters who now need more than ever a good treatment program because of the "creaming off' process that I have perceived of in this city in the last 3 years. The kids and the young people we have now need the best we have to offer.

Even as we move in the direction of trying to improve or close-down or whatever it is that we are after with institutional placement, and develop community based programs, let us keep a proper amount of resources in them and develop some way of phasing out institutions so they will not be left with a population that cannot be cared for because we have turned our backs on them in trying to induce the State to move in another direction.

I will ask Ms. Harrell to speak briefly and outline the project on what we hope to accomplish with this in our efforts in the NDC, she will be glad to proceed.

Ms. MARTINEZ. Yes.

Ms. HARRELL. Thank you, Madam Chairman.

The District of Columbia project funded by the National Center of Child Abuse and Neglect, which has been described and which you also have a more thorough description of in the written testimony, has two basic thrusts. The first is to allow a self reporting of abuse by the institutionalized youngsters.

These two institutions which are the target of the project are both institutions for older delinquent and allegedly delinquent youth in the 14 to 18 youth range.

It will test a procedure by which they can report that they feel they have been hurt or abused by staff member or by another resident into a system of boxes which will be emptied and investigated by independent investigating arm.

Yesterday, in meetings at the national center, there were a lot of discussions as to whether that would work, and we do not know whether it will or not. We have never tested whether, to be able to report themselves, someone is hurting me or "someone might hurt me" would be a better method. That is one of the arms of the project.

The other is an attempt to reduce the level of tension and confrontation between the staff and resident group with the provision of advanced counseling grants on a psychodrama model, allowing them to test out different ways to deal with daily confrontations with youth, the disrespect as it is sometimes called, the anger that goes on between staff and these residents before it gets to the point of either physical or psychological abuse.

It is a training mechanism.

Those are two major thrusts.

The project at this point is still in the startup phase and we hope to have at least some findings to report soon.

Thank you for your attention.

Ms. MARTINEZ. We may have written questions for you later.

[The prepared statement of Mr. Barr follows:]

INVESTIGATION AND CORRECTION
OF
INSTITUTIONAL CHILD MALTREATMENT

Testimony Prepared for Delivery Before
Subcommittee on Child and Human Development
Human Resources Committee
United States Senate
January 24, 1979

William W. Barr, Administrator
Social Rehabilitation Administration
Department of Human Resources
District of Columbia

Mr. Chairman, Honorable members of the Subcommittee, Ladies, and Gentlemen, I appreciate the opportunity to appear in this forum.

My name is William Barr. I am the Administrator of the Social Rehabilitation Administration of the Department of Human Resources of the District of Columbia.

I will testify on the subject of the maltreatment of children and youth in residential institutions, and about the District of Columbia's attempts to address the problem, including the demonstration project funded by the National Center on Child Abuse and Neglect of the Office of Human Development, Department of Health, Education and Welfare.

My institutional experience was gained in youth correctional institutions, and therefore my testimony will chiefly be germane to institutions serving delinquent and allegedly delinquent children and youth--that is, whose populations are basically hostile to adult authority and society's trappings and for the most part unwillingly institutionalized.

There are probably many parallels with institutions serving PINS, to some extent with those serving emotionally disturbed youth, and to a different degree with those with an educable retarded population. The issues may well be quite different in institutions serving severely and profoundly retarded persons and very young dependent children.

I will not address, in this setting, the issues of whether or not juvenile offenders should be institutionalized at all, or if so which ones and at what point in their "careers" and for how long. I am presuming for these purposes that some segments of society acting through its legislative and judicial arms will continue to feel that some youth who have seriously and repeatedly broken its laws should be institutionalized either to effect their habilitation or to protect society from their lack of it.

I realize that my perspective on this complicated issue of institutional child maltreatment is skewed, despite my social work training, by my position as Administrator of the Social Rehabilitation Administration of the District of Columbia's Department of Human Resources. This large umbrella agency's functions include, among many others, the administration of the District of Columbia's three institutions for delinquent and allegedly delinquent youth. I am thus responsible not only for protecting the welfare, the rights, and the mental and physical health of the youth committed to the Department's care, but also for guiding and monitoring the actions, preventing or assuring disciplinary action for the sins of omission and commission, and protecting the rights of the staff who work in the institutions.

What is "Institutional Abuse?" How does it differ from abuse in a child's own home? Who are the actors? What is the atmosphere?

I will examine in turn: the nature of institutional abuse, the children, the adults, the atmosphere, the allowable sanctions, and the available support.

The Nature of Institutional Abuse

We define Institutional Abuse, in the first instance, as inappropriate and unwarranted use of physical force against a child. (The use of physical force is specifically allowed to institutional personnel in District of Columbia institutions in carefully defined situations, i.e., in defense of themselves, other employees or residents, to prevent an escape or serious injury to personnel or serious property damage, or to quell a disturbance not otherwise controllable. However, only that amount of force necessary to accomplish the desired result is allowed.)

Child maltreatment also occurs in institutions in a number of ways other than through the use of physical force. One such "non-violent" form of mistreatment is the use of room seclusion for extended periods of time or other than when all less severe forms of restraint or punishment have been exhausted.

Other examples are more subtle or seemingly minor, but are probably equally dangerous in terms of their potential for building up to an explosion of anti-social behavior and their long-term dehumanizing effects on the children and staff. They include capricious withdrawal of small privileges which are important to the children, verbal harassment, demeaning remarks, and general lack of civility.

The Children

To what extent can we generalize about the children and youth who are resident in our training schools and detention centers?

Certainly many are frightened of the situation, of their peers, of the staff. Many are homesick. They are undisciplined almost by definition. They lack self-discipline and need adult direction. They have, by and large, had too little childhood, and been forced too early to learn to live by their wits in a hard "street society." In the institution they are sometimes hurt, and they have had very little way to tell anyone about it.

But, on the other hand, some are dangerous based on their demonstrated behavior. The majority of those in the care of the District of Columbia have committed crimes against persons, or major property crimes. Moreover, they are growing from children into men and women in a setting which has a mandate from the community to be highly structured, and which therefore is able to forgive very little of even the normal adolescent testing of adult authority. And it is not a setting of their choice.

The fact that a young person has been understood too infrequently, loved too little, and educated too poorly does not make him less cunning, less manipulative or less dangerous. This is one of the great dilemmas in the management of youth institutions. Our view of our residents must constantly be dichotomized--it must always be both compassionate and realistic.

The Adults

If, as the posters tell us, being a parent is the toughest job in the world, surely being a line cottage life staff member in an institution for children and youth must run a close second. The role of the surrogate parent who must exercise authority over these youths has many limitations.

The pressure on institutional workers is unremitting. The small, mundane, often reasonable requests and demands of fifteen to twenty youth, their petty quarrels, even their minor triumphs and achievements often bombard the staff member incessantly for the entire eight-hour shift. There is often no opportunity to "escape" for a cup of coffee or a minute's reflection. "Burn out" tends to come early and remain a constant problem to even the most dedicated staff.

The very overtime work which is practically inevitable given the twenty-four hour nature of the operation, and which, it must be admitted, makes being a cottage counselor more financially palatable to staff who might not be attracted to the base salary of the position, also increases the likelihood that cottage counselors will be tired, with the impatience and lack of perspective that mental and physical weariness brings with it.

I am convinced that just as parents do not wake up in the morning intending to abuse their children, neither do institutional staff come to work at the beginning of their tour of duty intending to mistreat the young people committed to their care. On the contrary, institutional mistreatment follows out of the gradual development by a staff member of a pattern of reacting impulsively and impatiently to residents and of resorting more and more frequently to physical solutions to problems of confrontation and challenged authority. However, our personnel records of 25 years indicate that the overwhelming majority of our staff have been very successful in developing positive relations with youth under their care which have carried over in to the adult years of the youth. In fact, one of my personal frustrations over the years has been that the climate created by staff in the institutions has been so supporting to youth that it caused a certain dependence on the structured regime of social living to develop among many youths. You have no doubt heard this phenomenon referred to as "the institutionalization process" which most likely will occur when youths enter institutions at the pre-puberty stage and spend too many of their developing years in and out of such settings. We as a staff have frequently been relieved when some youths continued to search for this structure in the military service rather than adult prisons!

The effort, it seems to me, of institutional staff must be to make a youth physically and developmentally comfortable while discouraging the youth from becoming psychologically comfortable, even as they deal with the total growth and development. This is not easy!

A basic premise of the Social Rehabilitation Administration's demonstration project in the area of institutional mistreatment is that these patterns can be detected before they become abusive, and rechanneled more constructively.

We believe that management has a continuing responsibility to evaluate the dynamics of the institution to assure measures to offset the human weaknesses of staff and to make the highest common denominator of staff efforts one that comes out at an acceptable level of treatment for youths.

The Atmosphere

As we attempt to understand why institutional abuse occurs and how it can be corrected and prevented by painting the picture of youth and their adult care-givers reacting to each other in the residential institutional setting, it is important to note some differences in the atmosphere that exists between children and parents in their own homes and children and staff in an institution.

In a healthy family setting we may certainly assume that an atmosphere of love and respect exists and underlies the dealings of family members with each other. Thus, the efficacy of a piece of advice or a reprimand given to our own children depends probably to some extent on its wisdom or our ability to enforce sanctions, but to a much larger extent upon our childrens' love and respect for us as parents. (Even in the most "unhealthy" abusive families there is usually a large reserve of love of children for their parents.)

The important difference in an institution is that we cannot assume a similar atmosphere of love and respect. Initially, most youths approach the institution with resentment and hostility--and some retain that attitude throughout their stay. However, the record shows that most youths will become more accepting of the environment as time passes and good surrogate relationships develop with the staff. Of course, this depends a great deal on whether the institution is custodially or treatment-oriented. "Custody" or "treatment," in my opinion, involves the structure and use of the physical plant, availability of an array of program services and activities, the language and action of staff directed toward youths, the personal response of staff to language and action of youths, and so forth.

A reprimand or direction given to a youth in an institution, unless backed up by indisputable logic or clear sanction, will frequently be greeted by evasion, jeer, or stony silence--even as may occur in the child's home.

A further difference between institution and home is that although a child in a family context is usually most unwilling to admit to others that abuse has taken place, or especially that the parent is the abuser, in many cases inventing explanations for injuries which would avoid implicating a parent, youth in a training school setting do not tend to be similarly inclined. In fact, knowing what serious misconduct physical abuse is for a staff member who perpetrates it, it is not uncommon for a youth either to invent instances of abuse or exaggerate descriptions of maltreatment in order to "get" a staff member who has possibly meted out some perfectly legitimate discipline for some perfectly legitimate reason.

Finally, parents receive a great deal of support from their children. These are often subliminal "strokes" which nonetheless helps to keep parents involved, to reduce parental "burn out." Institutional workers who care for other people's children receive very little of this kind of support.

The Allowable Sanctions

Although institutional staff must assume most of the "parenting" responsibilities for the young people committed to their care, including those of providing guidance, direction, and correction, they may not function in loco parentis when issues of discipline and punishment are involved. Society imposes restrictions on institutional staff when it comes to disciplining or punishing their charges, very rightly I believe, which are far more stringent than those which it imposes on parents punishing their own children.

There cannot and must not be any striking, slapping or spanking. There may be no "no dessert" or "bed without supper." There is no automobile to remove, personal possessions (radios, etc.) are few and far between, "dating" is usually non-existent, and threatening a youth in training school with "grounding" is ludicrous!

This is not to condone the use of any of these devices by parents, although their use in moderation is certainly widespread. It is simply to state that although we have an institutional situation in which the threats of sanctions must often provide a poor substitute for an atmosphere of love and respect, there are very few legal sanctions available to institutional workers. There is, afterall--at least in my opinion--a certain artificality about the institution (or any other surrogate situation) that precludes the assumption that methods of discipline employed in the home can be used successfully in institutions. It should be noted, however, that several psychiatrists over the years have told me that the institutional regulation prohibiting corporal punishment is in itself artificial and denies the opportunity to correct a youth in a non-brutal way as is done in many if not most families. It is always a debatable issue, it seems to me.

The Available Supports

There have traditionally been too few supports available either for institutionalized children who feel that they have been mistreated by staff, or for staff who find themselves unable to cope with the unremitting pressures which their jobs entail.

The children have traditionally not had ready access to adults other than the peers of the feared staff member. The staff, lacking an appropriate forum to admit and discuss their own problems in dealing with the children, have struggled with the issues largely isolated from each other or from any help which they could possibly receive.

What a Solution must offer:

The decision was made that any "solution" to the problem of the abuse of young people in the District of Columbia institutions for delinquent and allegedly delinquent youth must allow the following:

1. It must, first and foremost, protect the health and welfare of the institutionalized child by establishing a mechanism by which the child may report having been hurt or being afraid of being hurt to someone other than the alleged or prospective assailant (or the assailant's peers). The system must ensure a prompt, impartial hearing of the child's story in an atmosphere as devoid as possible of fear of retaliation.

2. It must protect the rights of the institutional staff member by making certain that the staff side of the story is also heard promptly and impartially by persons who understand all of the factors which operate in an institutional setting.

3. It must assist the Department in saying to all of its staff "there are some things you must not do, ever, no matter what the pressures on you may be. If you do them, you will be promptly and severely disciplined." It must then assist the Department in disciplining, removing from a child-contact position, or removing from employment, as appropriate, any staff member who mistreats or abuses any institutional resident.

4. On the other hand, it must aid the Department in identifying "high risk" staff members before their impatient or overly defensive or physical patterns of relating to residents develop into patterns of abuse, and it must provide a way to give these and other staff the support and help they need to sustain their morale and improve the quality of their relationships with residents.

The Demonstration Project:

The Social Rehabilitation Administration of the Department of Human Resources has been awarded a demonstration grant from HEW's Office of Human Development (National Center on Child Abuse and Neglect). The grant, which is in the amount of $79,950 for FY '79, and which is projected to continue for three years, provides for the establishment of a two-fold project at the Institutional Care Services Division, comprised of the three residential institutions for delinquent and allegedly delinquent youth (Cedar Knoll, Oak Hill and the Receiving Home).

The first aspect of the project will allow residents to report mistreatment by signing their name to a form and depositing it directly into a locked box located in their living quarters and other areas to which they have ready access. Line staff will not be able to open the boxes.

Project staff will receive these forms and interview daily each resident who has submitted one to determine what substance there may be to the complaint. All "Unusual Incident Report" forms from the institution will also be reviewed each day to compare staff versions of incidents with resident versions. If it is determined that there is "probable cause" to believe that some mistreatment of a resident has occurred, an Investigatory Hearing involving project staff, residents and staff members will be convened to be certain that both sides of the story are adequately explored, and to make recommendations to the Administrator, Social Rehabilitation Administration, if further action is indicated.

The second aspect of the project is designed to reduce the level of tension and confrontation between residents and staff at the institutions by making available continuing Advanced Counseling Groups for staff in which alternative means of dealing with confrontational situations will be explored and discussed. In addition, these Advanced Counseling Groups will provide a forum for planning (and providing resources on a limited scale for) staff-designed program activities, on the theory that staff and residents who are involved together in program activities are less likely to react to each other in ways that will lead to physical confrontations.

There will be four grant-funded positions to be filled: a Project Director, two Investigators, and a Clerk.

At this point, it is too early to determine results from the demonstration project. We are still in the "start up" phase of hiring staff, modifying and installing locked boxes, letting the contract for the leadership of the Advanced Counseling Groups, and developing procedures for project operation.

We are aware that the results will be difficult to quantify at first, since the introduction of a new reporting mechanism will at least temporarily increase the number of instances of mistreatment reported. We are confident, however, that the dual supports for youth and staff which the project will provide will lead to a generally better institutional atmosphere, a lessening of tension between residents and staff, and a subsequent reduction in the number of youth whose institutional stay is marked by conflict and abuse rather than help.

We are certain that what we will learn can be utilized by other jurisdictions as they address their own institutional problems.

Again let me thank you for this opportunity to testify before the subcommittee. I would be happy to answer any questions that you may have.

Mr. Smiles.

Mr. **Smiles.** I am Gregory Smiles, project director on institutional child abuse, division of youth and family services, Department of Human Services, State of New Jersey.

On behalf of New Jersey Youth and Family Service, State child protective agency, I want to thank you for the opportunity to present testimony.

The division of youth and family service in New Jersey is statutorily mandated to conduct investigations within institutions. Although we are a State agency, we are an independent agency of the institutions.

If there is an investigation conducted in one of our facilities, it is conducted by another outside State administrative agency. I am not going to go over individual components of our project. I would just like to discuss three major issues which the demonstration project feels is the core keeping child abuse and neglect and residential abuses at a minimum.

First, you will note that in the written testimony through formation of statewide task force, we are interested in forming a formal advocacy and advocating system for children's institutions. Such a system proposes to be similarly independent of the institution itself.

The question arises of why a system is needed since these facilities were established originally and continue to operate out of the concern for our children. There is no doubt that the majority do this; however, there is also the fact that much too often institutional employees and officials, although competent and concerned, become immune to their own system's inadequacies. A deficiency in their organization is often overlooked or treated as an unrepairable reality. It is understandable that no human delivery system can be totally free of "abuses" but, in light of the fact that some of the most vulnerable children in the world are being abused, we cannot treat the inadequacies of the institutional system lightly. Like the many other systems in our society which employ a "watch dog" mechanism, children's institutions also need to be watched by a third eye.

The second major issue involves the development of procedures that will insure that all abuse inside the institutions are reported to the State's protective service agency. This area should be of grave concern to all of us since it reminds us of the fact that only the people inside these facilities are aware of what occurs on a day-to-day basis. While the number of reported abuse incidents in New Jersey has substantially increased over the past year, the project is greatly concerned about the abusive incidents which are not reported. Too many of us here today are unaware of this statistic.

It is for this reason that it is imperative that we do not allow our institutions to become socially and physically isolated from our communities. They, in fact, should become an integral part of a community by sharing and utilizing resources of the community and letting the community know what occurs within their walls. The American society, the professions of psychiatry and psychology, and others, have made progress toward this goal and in deisolating our institutions. This progress, slow as it may be, has led us to the current movement of deinstitutionalization, a movement I am proud to say that the State of New Jersey has made a commitment toward. The correct implementation of a deinstitutionalization plan will undoubtedly eliminate many of the abusive practices which these children are subject to because it will let us know, as private citizens, how the children are being treated.

You will also note that the project has an emphasis geared toward the child care staff of institutions. During the course of the day's testimony, some speakers have discussed the difficult role these workers must fulfill. I want to just mention that a major goal of this project is to begin an effort in New Jersey to recognize the importance of this position within the institutional system. For too long, this position has meant very little in New Jersey, and in many other States. It is our hope that all child care workers will soon become professionally recognized and that efforts are made to reduce the type of pressure they are forced to work under.

We are fortunate in New Jersey to be given the stimulus by the Department of Health, Education, and Welfare to correct the problem of institutional child abuse. It is hoped that in the future the Department of Health, Education, and Welfare, through the National Center on Child Abuse and Neglect, makes similar projects available for other States so they, too, can investigate the problem and share their findings to all interested organizations. Obviously, much more information is needed in the subject. It is also hoped that the Federal Government recognizes the need to assist States in other areas directly related to the care of institutionalized children. Such areas include providing incentives to deinstitutionalize our institutional populations and providing incentives to establish better overall child mental health systems, which have been neglected for too long within the mental health field. Similar neglect has also been witnessed in our juvenile justice system. The current attitude toward juvenile delinquency commonly fosters abuse on all levels. States should also be encouraged to establish extensive and specialized training centers for personnel of children's facilities; this training, which has been continuously ignored in the past, should focus on all levels of the institutional staff.

There will, of course, be other issues which will arise in the future and that will need further investigation as States begin to objectively look into the operations of their children's facilities. The national effort is to correct the problem and is just the beginning. We in New Jersey only hope that this effort never ceases and urge that this subcommittee do everything within its power to insure that the effort is carried on in the years to come.

Thank you.

[The prepared statement of Mr. Smiles follows:]

TESTIMONY OF GREGORY SMILES, PROJECT DIRECTOR
ON INSTITUTIONAL CHILD ABUSE
DIVISION OF YOUTH & FAMILY SERVICES
DEPARTMENT OF HUMAN SERVICES, STATE OF NEW JERSEY

BEFORE

THE SENATE SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT
AT HEARINGS ON THE ABUSE OF CHILDREN IN INSTITUTIONS

Submitted January 17, 1979

I would like to thank you for the opportunity to present testimony on the abuse of children in institutions. As you may be aware, New Jersey is one of the four states that was awarded a demonstration grant from the National Center on Child Abuse and Neglect of the Department of Health, Education & Welfare on the investigation and correction of child abuse and neglect in residential institutions for Fiscal Year 1978. New Jersey is enthusiastic about the reception of the grant and is determined to utilize the project to its' fullest potential.

We feel that we are in a position to gain excellent results from the project since as a State, we have already begun efforts to correct this growing problem. I want to acknowledge that these efforts were facilitated by a supplemental grant from the National Center received last year. This grant essentially established my position as coordinator for institutional abuse matters in New Jersey.

The following testimony will describe what the New Jersey Division of Youth and Family Services has done and what it plans to do in the future as it pertains to the investigation and correction of child abuse and neglect in residential institutions.

I. The Role of the Division of Youth and Family Services in the New Jersey Protective Service System

The Division of Youth and Family Services is the primary child and family social service agency in the State of New Jersey providing a variety of services including counselling, foster and residential care, adoption investigation and supervision, parole supervision, day care, homemaker, family planning and WIN services. These services are provided by casework staff in 25 district offices, administered by a Central Office in Trenton. The Division also supervises the social service units of the county welfare agencies and is the state agency responsible for the administration of both the direct and purchased Title XX service programs under the overall direction of the New Jersey Department of Human Services.

The Division's most important role stems from its legal mandate to provide protective services to children and families suffering from abuse and neglect situations. This mandate covers both abuse in the child's home and in situations where the child is abused by a "parent substitute". These latter situations mostly involve children in residential institutions but also cover day school placements and the like.

The Division's protective service system consists of the following components:

Reporting

Under State statute, the Division must operate a 24-hour emergency telephone service for the receipt of all child abuse reports from any person in the community. This, of course, includes incidents of institutional abuse. Referrals are received at the local district office during business hours and at the Central Office of Child Abuse Control (OCAC) at any hour (800-792-8610). Information from reports is kept in a confidential Central Registry information system.

Investigation

Investigations of referrals of institutional child abuse are made within 24 hours; investigations of neglect referrals are completed within 72 hours. In this process, contacts are made with the institution, the alleged perpetrator, the child, the referrant, and the collateral sources involved. Responsibility for the initial investigation is shared as follows:

1. On week nights, weekends and holidays, Special Response Units operated

by each district office respond to emergencies referred by OCAC. These units are staffed by professional social workers who make immediate contact with the institution to insure the safety of the child.

2. During regular business hours, all institutional abuse investigations are handled by the district offices who compile their findings in reports and make recommendations for corrective or preventive measures.
3. Their findings and final reports are submitted to the Division's Deputy Director, who then forwards it to the Institutional Abuse Project Director. The Project Director reviews the investigative results and prepares them for the Commissioner of the Department of Human Services. Within this report, recommendations for corrective and preventive actions are made. If the abuse occurred in an institution which is under the supervision of the Department of Human Services, the report is sent to the Director of the appropriate placing Division (i.e., the Division of Mental Retardation, etc.). If abuse occurred in a state-run institution not under the jurisdiction of the Department of Human Services, the report is sent to the Commissioner of the supervising Department (i.e., Department of Corrections). If the institution is county operated, it is sent to the County Board of Freeholders' Office. If abuse or neglect is substantiated, and corrective action is recommended, the governing body is given 30 days to take such action and to inform the Commissioner of the Department of Human Services of progress made. The Division can request this action by utilizing their statutory mandate to recommend remedies in cases of child abuse or neglect.
4. The Division of Youth and Family Services itself operates a small number of institutions for children in the State. While Division Protective Service workers conduct investigations into these facilities to meet their legal mandate and insure the safety of the children, an independent investigation is also conducted by the N.J. Department of the Public

Advocate - a separate agency - who insures that corrective and preventive measures are taken after abuse incidents in Division facilities. This agreement was reached in 1976 and was made between the two departments, effective by an issuance of the Department of Human Services Administrative Order on Institutional Abuse.

II. With the establishment of the Project Director's position in 1978, the New Jersey Division of Youth and Family Services has been able to begin to identify the major areas that need to be resolved if an effective reporting, investigating, responding and preventing capability is to be developed. They are:

1. Public awareness of the problem of institutional abuse needs to be further brought about.
2. Institutional personnel are not always aware of the legal responsibility to report child abuse and neglect in institutions and are not always aware of the proper methods to manage children which are not abusive.
3. Institutions do not always possess internal procedures for immediate investigatory and corrective action that ensures the safety of the children (medical treatment, removal of staff, etc.).
4. DYFS field staff require additional and continual technical support when investigating child abuse reports in institutions.
5. At present, procedural safeguards do not exist that ensure that corrective action has been taken by the institution after an incident of abuse or neglect has been substantiated.
6. The lack of knowledge regarding long-term preventive measures that will decrease the incidence of child abuse and neglect in New Jersey institutions.

7. And most of all, public and private agencies in New Jersey concerned or professionally affiliated with the care of children in residential institutions have recognized that the problem of institutional child abuse does exist. Preliminary statistics indicate that approximately 130 institutional abuse incidents were reported to the Division of Youth and Family Services in 1978. Physical abuse was the most prevalent form; however, institutional abuse also takes the form of sexual and emotional maltreatment, as well as child neglect. Be advised that these were only the cases that were reported to the State's Child Protective Service agency.

III. After these areas were identified, the Institutional Abuse Project Director began a statewide effort to resolve some of these issues. Some accomplishments that were made during 1978 were:

1. A review of the state policies and procedures on institutional abuse - Changes in the existing corps of administrative orders have been proposed by the Project Director and are currently being reviewed and discussed with the Division of Youth and Family Services Deputy Director, the Office of the Commissioner of the Department of Human Services and its subordinate Divisions, other State Departments who control - directly or through contract - child caring institutions, the Division's own Bureau of Residential Services, and the Division's office of Program Support and Policy Development.
2. The development of guidelines with specific State governmental units which oversee and direct the operations of child caring institutions - These guidelines define abuse and neglect as

well as insure that every residential institution employee is made aware of the statutory reporting requirements and the specific procedures to be followed in reporting child abuse and neglect within their institutions. The guidelines have been developed jointly by the Division of Youth and Family Services Institutional Abuse Project Director and staff of the New Jersey Department of Corrections, the New Jersey Division of Mental Health and Hospitals and the New Jersey Division of Mental Retardation.

3. Holding informal meetings with several public and private agencies to inform them about the incidence and nature of institutional abuse and neglect and the Division's role in investigating such allegations - At these meetings, tentative commitments to work together on this problem have been agreed upon.

4. Conducting two training workshops for Division of Youth and Family Services investigatory caseworkers - Specific issues on institutional abuse were addressed and discussed by representatives of the different State Divisions/Departments who operate or contract with child caring institutions. Such issues raised were:
    a. the need to further emphasize the responsibility to report institutional abuse;
    b. the need to devise means to allow for children in institutions to report abuse;
    c. placement workers maintaining contact with children in institutions;
    d. medical neglect in institutions;
    e. adequate vs. optimal care in terms of neglect - developing

a definition; and

f. follow-up on corrective action.

5. Providing technical assistance to field officers conducting investigations on a regular basis.

6. The continued processing of investigations that are conducted by the Division of Youth and Family Services protective service workers - This includes reviewing the reported findings, preparing the final reports and making recommendations for corrective and preventive actions.

7. Mounting a new effort to establish contact with County-run institutions where the State has very limited influence over the operation of such facilities.

8. Convening a statewide conference on institutional abuse - The conference was attended by institutional staff, child advocates and private citizens. The conference was viewed as a critical component, as a beginning toward increasing public awareness of the problem.

9. Generating a substantial increase in the reporting of institutional abuse or neglect incidents - In 1978, there was a 54% increase over 1977 in the reporting of institutional abuse incident to the Division of Youth and Family Services.

10. Conducting a series of training sessions in child-caring institution on the child abuse law and non-abusive techniques in managing institutionalized children

IV. Although the Division has made what we feel is substantial progress toward combating the problem of institutional abuse in New Jersey, we are also aware that much more work is needed in order to control it. Because of this, we sought and received a three year grant from the

National Center on Child Abuse and Neglect. By reception of the grant, we feel that New Jersey now has the potential to greatly reduce the amount of institutional abuse that occurs in this State. This potential lies in the fact that the grant offers concrete solutions to the problem. These solutions are preventive in nature and if their implementation is successful, will have benefits for the institutionalized children of New Jersey and for any other State who would like to follow our path.

The main highlights of the project and the description of this preventive approach are as follows:

1. An analysis of the reports received in 1978 indicate that child care workers are often not aware of proper techniques to restrain children in a safe manner; are unable to effectively handle crisis situations within institutions in a safe manner; and work under considerable stress because the children they care for often require constant attention and supervision to meet their "special" needs. In addition, these employees are frequently the lowest paid personnel in the institutions, have little chance for upward mobility, and hence, lack incentive to perform their jobs with care and efficiency. There is a need to further investigate why abuse occurs at this level and to determine what measures can be taken to prevent it from occurring or recurring.

   The Project intends to fully analyze the etiological factors of child abuse and neglect in institutions. It will focus on why abuse appears to occur at the child careworker level. It will analyze the conditions under which these workers must perform and their needs with regard to providing children with care in a safe manner. It will investigate the relationship of abuse with institutional staff selection procedures and their policies related to child care. It will research current and past training techniques that have been developed for dealing with institutional abuse. The Project will conduct surveys in the institutions to assess the needs of the child care worker. The information obtained from the research component will enable New Jersey to identify why abuse occurs in its institutions and what measures can be taken to stop it.

2. The Project will train institutional personnel as to what constitutes abuse and neglect in institutions and the reporting requirements based upon the State guidelines developed with the various institutional agencies. The training will also focus on the employment of non-abusive child management techniques. This instruction will be geared toward all levels of personnel in the institution (child care staff, professional treatment staff, etc.) and will be designed in such a way that the individual agencies can continue the training on their own. This part of the Project will not only insure that New Jersey personnel involved in the institutional care of children are aware of the reporting requirements and procedures, but will provide an increase in protection for these children from those who would abuse and neglect them.

3. The Project will develop and conduct training on how to perform expert abuse investigations in children's institutions. It will focus on investigatory techniques and the broadening

of the caseworker's awareness on the types of children in the different institutions and the operations of institutional life. Such training will enable the Division of Youth and Family Services' caseworkers to identify potentially abusive institutions before abusive patterns begin in a facility.

4. At the end of the first grant year, the Project Director will begin concentrating on maintaining, and building further, private and public interest and awareness of institutional abuse and neglect - This will involve conducting meetings and workshops with interested citizens and public officials who have previously expressed concern about abuse and neglect in institutions, as well as new pools of interested people. This process will involve obtaining firm commitments to cooperate in efforts to eliminate abuse and neglect within New Jersey institutions. Once commitments are secured, a Task Force will then be formed. Proposed membership for the Task Force wi-l include: private citizens groups, private citizens, New Jersey Department of the Public Advocate; The Public Defender's Office of the Department of the Public Advocate, County Prosecutors, a Deputy Attorney General; and representatives from each State agency that operates or oversees the operations of child caring institutions. The feasibility of obtaining State legislators will be considered.

The Task Force will address and review issues around institutional abuse. While general policies and procedures will be analyzed, the specific goal of this multi-disciplinary Task

Force will be the development of a corrective follow-up method after an abuse incident has been substantiated. The Project Director expects that more than one method will be tested during the three year period, with the most effective and reasonable one being recommended for general implementation. Three alternative models to be discussed will be 1) internal advocacy programs within the institutions, 2) a State-administered advocacy program, under the direction of the individual supervisory State Divisions or Departments, and 3) a Citizen Advocacy program. The employment of the Task Force as an advocacy model will also be explored.

5. The Project Director will complete the agency-specific guidelines on the reporting of abuse and neglect for those child placing provider agencies for which guidelines have not been completed under the 1977-78 grant - In addition, it has become known to the Division of Youth and Family Services that many county institutions do not have written internal procedures for handling child abuse or other unusual incidents which may pose a threat to the welfare of one or more children. The lack of such procedures prevents immediate corrective action to insure the safety of the children residing in these institutions. It also hinders the performance of a smoothly functioning daily routine. The Project Director will work with various county representatives to develop these initial policies and procedures for the institutions.

6. In addition to the above highlights, the Institutional Abuse Project will be available for consultation on institutional abuse matters to all State agencies as well as other national organizations. It will constantly review State procedures

and explore the possibility for legislation on institutional abuse issues. More important, this Institutional Abuse Project will signify that New Jersey is not going to forget about its children who are residing in residential institutions.

V. Behind the selection of these highlights are three major issues which this demonstration project feels is the core at keeping child abuse and neglect in residential institutions at a minimum. First, you will note that through the formation of a Task Force, we are interested in establishing a formal advocacy and monitoring system for our children's institutions. Such a system proposes to be semi-independent of the institution itself. The question arises of why a system is needed since these facilities were established originally and continue to operate out of the concern for our children. There is no doubt that the majority do this; however, there is also the fact that much too often institutional employees and officials, although competent and concerned, become immune to their own system's inadequacies. A deficiency in their organization is often overlooked or treated as an unrepairable reality. It is understandable that no human delivery system can be totally free of "abuses" but in light of the fact that some of the most vulnerable children in the world are being abused, we cannot treat the inadequacies of the institutional system lightly. Like the many other systems in our society which employ a "watch dog" mechanism, children's institutions also need to be watched by a third eye.

The second major issue involves the development of procedures that will insure that all abuse inside the institutions are reported to the State's Protective Service agency. This area should be of grave concern to all of us, since it reminds us of the fact that only the people inside these facilities are aware of what occurs on a day to day basis. While the number of reported abuse incidents in New Jersey has substantially increased over the past year, the Project is greatly concerned about the abusive incidents which are not reported. Too many of us here today are unaware of this statistic.

It is for this reason that it is imperative that we do not allow our institutions to become socially and physically isolated from our communities. They, in fact, should become an integral part of a community by sharing and utilizing resources of the community and letting the community know what occurs within their walls. The American society, the professions of psychiatry and psychology and others, have made progress toward this goal and in de-isolating our institutions. This progress, slow as it may be, has lead us to the current movement of deinstitutionalization, a movement I am proud to say that the State of New Jersey has made a commitment toward. The correct implementation of a deinstitutionalization plan will undoubtedly eliminate many of the abusive practices which these children are subjected to because it will let us know, as private citizens, how the children are being treated.

You will also note that the Project has an emphasis geared toward the child care staff of institutions. I'm sure during the course of the day's testimony, many speakers will discuss the difficult role these workers must fulfill. I want to just mention that a major goal of this Project is to begin an effort in New Jersey to recognize the importance of this position within the institutional system. For too long, this position has meant very little in New Jersey (and in many other States). It is our hope that all child care workers will soon become professionally recognized and that efforts are made to reduce the type of pressure they are forced to work under.

VI. Concluding Remarks

We are fortunate in New Jersey to be given the stimulus by the Department of Health, Education and Welfare to correct the problem of institutional child abuse. It is hoped that in the future, the Department of Health, Education and Welfare, through the National Center on Child Abuse and Neglect, makes similar projects available for other States so they, too, can investigate the problem and share their findings to all interested organizations. Obviously, much more information is needed on the subject. It is also hoped that the federal government recognizes the need to assist States in other areas directly related to the care of institutionalized children. Such areas include providing incentives to deinstitutionalize our institutional populations and providing incentives to establish better overall child mental health systems, which have been neglected for too long within the mental health field. Similar neglect has also been witnessed in our Juvenile Justice system. The current attitude toward juvenile delinquency commonly fosters abuse on all levels. States should also be encouraged to establish extensive and specialized training centers for personnel of children's facilities; this training, which has been continuously ignored in the past, should focus on all levels of the institutional staff.

There will, of course, be other issues which will arise in the future and that will need further investigation as States begin to objectively look into the operations of their children's facilities. The national effort to correct the problem is just beginning. We, in New Jersey, only hope that this effort never ceases and urge that this sub-committee do everything within its power to insure that the effort is carried on in the years to come.

Mr. Aber. I will be very brief. I would like to do two things. I would like the opportunity to review the testimony and comments of Senator Backman from Massachusetts because I think that some of the issues which he raised and some of our responses could shed tremendous light for the subcommittee on the advocacy effort within the context of State government for kids in institutions.

In my opinion Senator Backman's testimony and the hearings he held in Massachusetts in November, should be reviewed very closely by the subcommittee because they document the morass of political and bureaucratic cross purposes and cross interests that operate in this area.

It also shows, I think, the very important role of legislative oversight in this area, and I think you would welcome some of our more detailed response to some of these issues.

Ms. Martinez. We would be glad to have those in the record.

Mr. Aber. The second thing I want to do is also respond in writing to any questions you have about our written testimony which I am going to completely skip. I would ask you to look at that closely, too, because that goes into details of our grant proposal and for the same reasons I will not go into all of that.

But, instead, I want to make four very general recommendations based on the comments today.

First, I think that through various mechanisms the Federal Government could ask and perhaps require State governments to come up with concrete State action plans to prevent institutional abuse of children and protect children in institutions.

Part of the problem of institutional child abuse is that within the highest levels of State government. There is nobody who feels they are singularly responsible for this problem. Institutional children would greatly benefit from some direction and encouragement on the Federal Government's part, not necessarily with overly burdensome regulations, but some requirements for state governments to appoint somebody to develop this plan and some review possibilities.

Second, one of the things that characterizes institutionalized children from children in homes is they do not have a person advocate.

Many of the reasons that children are institutionalized is that they do not have a parent who is willing, available or even exists to play that role for them.

I am not proposing anything that would weaken the role of the natural parent for every child in an institution who has a natural parent who is able to provide those kinds of things for the child. That role should be strengthened through increased visitation practices, through resources to help children go home on weekends, to prevent the long term isolation of the children from the home.

Everything should be done to strengthen the personal advocacy of natural parents. There is a line that is passed, though—where some children very simply do not have personal guardians. As a society, we hate to face up to that, but its true.

We cannot appoint the Department of Public Welfare or similar anonymous agencies to be the protector of a child and expect that anything will happen.

Those children do not have guardians in any vague sense of the term. I think that is something that the Federal Government could look into very clearly and perhaps propose legislation similar to the parent surrogate requirements of Public Law 94–142.

The third thing I want to support is Jerry Miller's analysis of a lot of the problems of institutional abuse of children as, in a sense, problems of the radical monopoly by the State governments in providing institutional residential services for children.

Children requiring residential care and their parents have virtually no choice in where the children are going to be placed.

In everything from telephones to oil, we have discovered that radical monopolies are not the best way to protect consumer interests. So, some way of building incentives to create choice for the children and the parents, rather than being a duplication of services which some budget cutters call it, is, indeed, an enhancement of the abilities to avoid abusive situations.

Programs should be able to compete with each other, to provide quality services for children. The difference between Yale University and Eau Claire Academy is striking. If you get into Yale University, you will get into Swarthmore and the University of Vermont and so you can choose which program best meets your needs. But Eau Claire Academy is probably the only game in town for the kids who have to go there.

Perhaps some kind of voucher system, which has been discussed many times in many ways, is something again that the Subcommittee could look at very seriously.

My bet is that any analysis of a voucher system would in the long run also show it to be a cost saving device.

The final thing that I would like to raise is that we have really talked less than I would like about the whole array of preventive policies and programs that State governments can employ in addressing the issue of institutional abuse.

I would like to elaborate on them on a later date, but everybody wants to go now. I will mention only two simple policies and programs and be done with it right now.

In Massachusetts, probably the greatest move toward the institutionalization of children comes from the child abuse reporting laws.

In the last 5 years, child abuse reports have gone from 2,000 a year in 1974 to an estimated 25,000 a year for 1979. Those are children who we often placed outside of their home and so are the newest sources of an institutional population in the State.

This is occurring at the same time as we are trying a massive deinstitutionalization program in our mental hospitals and state schools and new special education policies which try to provide services for handicapped kids at the local level and thus prevent residential placement.

We have got to start looking at the relationship between aggressive policies to help people in one way and their second and third term effect, which are clearly predictable, which may conflict with the policies in other ways.

We are right now creating a new institutional population by trying to protect children in homes. I do not purport to know a solution for that. I only know it is a terrible dilemma and a tremendous source of new recruits for our institutions.

A second policy that most States have not enacted is a rigorous way of examining whether relatives and family members can provide the kind of care that we now rely on Government to provide for children in crises or children who need protection.

There is litigation on this issue in Massachusetts, Lynch against Dukakis. It is the major case that explores the constitutional issues around that policy option and may end up deciding that children have the constitutional right to be placed with a relative or other family member before the State places them with a foster family.

In terms of program options, the whole range of programs like protective day care services or developmental day care services, and respite care and things that have been documented as having families take care of their children without requiring out of home placement—we have not talked that much about those either.

I would like to see more exploration by the subcommittee of those alternatives as strategies to combat institutional child abuse. Thank you.

Ms. MARTINEZ. Thank you. Thank each of you also for your testimony.

We do have some questions that we will be submitting in writing to each of you. Senator Cranston has indicated that he does intend to continue further the hearings on these issues, and we will be scheduling dates for those.

[The prepared statements of Mr. Abner and Senator Bayh follow:]

STATEMENT BY SENATOR BIRCH BAYH - JANUARY 24 - SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT

MR. BAYH: Mr. Chairman, I want to thank you for the opportunity to testify at this hearing on child abuse in institutions. I must commend you, Mr. Chairman, for your distinguished work in the entire area of child and human development over the years. I have been privileged to work with you on many subjects of mutual concern, but never, I am sure, on one that is more important or of greater personal concern than today's subject.

My interest in the area of child abuse in our nation's institutions began with my work as chairman of the Juvenile Delinquency Subcommittee of the Judiciary Committee. During my tenure as chairman of that subcommittee I was constantly appalled at the treatment of too many of our nation's institutionalized children, some of whom were guilty of anti-social acts and some of whom were not guilty of having done anything more than being truant or "incorrigible", whatever that may mean. An unpardonable number of our teenagers are locked up simply because their parents can not or will not care for them and the state can not come up with any better solution than a juvenile correctional facility.

During the last two years, I have once again become deeply involved in the question of child abuse in institutions through sponsorship of S. 10, legislation which you, Mr. Chairman, and 23 other of our colleagues have co-sponsored.

This bill would give standing to the Attorney General to initiate or intervene in actions on behalf of institutionalized persons in cases of widespread deprivation of Constitutional rights. The bill specifies that the conditions leading to the filing of a suit must be "egregious or flagrant," that they must cause grevious harm.

The institutions covered by this legislation include institutions for mentally ill, mentally retarded, long-term care or custodial facilities, juvenile detention or care facilities and jails and correctional facilities.

As you are aware, a number of these institutions would include children in their populations. For this reason, I was pleased that you invited me to testify at these hearings today.

I would like to spend a little time discussing the history of S. 10 and of Justice Department involvement in this type of action. The abuses we seek to redress are not insignificant nor are they merely technical. A brief look at the cases brought on behalf of the institutionalized will highlight the need for continued participation by the Justice Department. In the landmark case of Wyatt v. Stickney the Justice Department's ability to engage in long-term discovery was instrumental in developing a record of institution-wide abuses to which inmates of mental hospitals were being subjected.

In the course of litigation brought to correct abuses in a state's juvenile reformatories, a federal court found the state juvenile system rampant with officially sanctioned brutality, including beatings, tear gassings, and placement in homosexual dormitories as a form of punishment (Morales v. Turman).

Following Wyatt and other cases in which the Department participated, a number of states adopted statutes providing a right to treatment for mentally ill institutionalized persons, and a series of federal court cases further substantiated a Constitutional right to such treatment. The Department of Health, Education and Welfare followed suit by adopting many of the standards first enunciated in Wyatt as conditions for participation in federally funded programs of care for the mentally handicapped. Judge Johnson, who initially ordered the Department to appear as amicus curiae in Wyatt, was sufficiently impressed to commend government lawyers for having "performed exemplary service for which this court is indeed grateful."

The first serious setback to these efforts came in 1976 when a federal district court in Maryland dismissed a suit brought by the Justice Department concerning the conditions at the Rosewood State Hospital for the mentally retarded. In U.S. v. Solomon the court held that the Justice Department lacked inherent or common law authority to sue to enforce Constitutional and federal rights of hospital inmates. Following the Solomon decision, a federal district court in Montana dismissed another suit initiated by the Department challenging conditions in a state mental retardation hospital, again declaring that, absent express statutory authority, the Department lacked standing to sue.

This bill creates no new substantive rights, nor does it open the doors of the federal courthouse to a new class of litigants. Under the standards we have proposed, the authority of the Department to bring suit on behalf of the institutionalized is limited to cases alleging widespread deprivations of Constitutional and federal rights and then, as previously pointed out, only in the presence of "egregious or flagrant conditions." Clearly, the intent of this legislation is not to provide the Justice Department with standing to bring suit to redress minor or unimportant technical regulations. S. 10 is designed to redress the most horrendous of conditions, conditions which sometimes deprive institutionalized persons in this country of the very right to life itself.

Mr. Chairman, in five difficult days of hearings in 1977, we heard of children being beaten, starved, used as slave labor, involuntarily sterilized, placed for days, weeks, even years at a time in straight jackets and some being killed. A doctor from Willowbrook made the following statement: "The younger residents within the first year or two of coming to Willowbrook either learned ...how to swallow a large amount of food rapidly or they died." We learned about children who were placed in institutions to help them to learn and who, instead, received 1 hour of schooling a day and no training in how to care for themselves.

We heard about and from children who could not remember one day of love, of tenderness or caring. We heard about children who, had they been given the opportunity, could have led useful and productive lives but, instead, were condemned to a life of deprivation and institutionalization by being denied education and humane living conditions, by being denied the basic human dignity which is their birthright in our nation.

While I do not believe that S. 10 can solve all of the problems of our institutionalized persons, I do believe that it is a necessary and important tool to help us redress the most uncivilized kinds of abuse, too widespread to be handled by private plaintiffs or even such notable advocates for the developmentally disabled as the Protection and Advocacy agencies which are, in many states, understaffed and low on funds and do not wish to take on this kind of problem even with significant increases in resources but, prefer to refer such cases to the Justice Department.

There are those who have said that the federal government has no right to tell the states how to run their institutions. They have said that by forcing the states,/ through the legal process, to clean up their institutions, the federal government is telling the states how to allocate their funds. Mr. Chairman, we have made considerable provision to protect the legitimate rights of the states. We have set up certification requirements before suit can be initiated that include certification that the Attorney General has consulted with the state about financial and technical resources available to them.

In the end we must realize that the doctrine of States' rights does not include an unbridled right to ignore the Federal constitutional rights of human beings and to subject them to conditions that should not even be tolerated for animals.

Much has been said through the years about the conditions to which we subject our institutionalized children. It is my sincere hope, and I know it is yours, Mr. Chairman, that we will never again have to sit through days of hearings such as these or listen to a recital of living conditions that turn our stomachs, because such conditions will no longer exist. I believe S. 10 is one step in assuring that conditions in our institutions will continue to improve and that we will work to create an environment for all of our citizens that emphasizes, rather than destroys, their humanity.

Thank you Mr. Chairman.

Ms. Martinez. Since there are no further witnesses, these hearings are recessed, subject to recall of the Chair.

[Whereupon, at 1:47 p.m., the subcommittee adjourned, subject to the call of the Chair.]

ABUSE AND NEGLECT OF CHILDREN IN INSTITUTIONS, 1979

THURSDAY, MAY 31, 1979

U.S. SENATE,
SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT,
OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Los Angeles, Calif.

The subcommittee met, pursuant to notice, at 10 a.m., in the Washington Room, Los Angeles County Patriotic Hall, 1816 South Figueroa St., Senator Alan Cranston (chairman of the subcommittee) presiding.

Present: Senator Cranston.

Staff members present: Susanne Martinez, counsel; Mary Lopatto, professional staff member; and Cynthia Whitman, minority professional staff member.

Senator CRANSTON. The hearing will please come to order.

This morning the Subcommittee on Child and Human Development begins the third in a series of hearings looking into the problem of abuse and neglect of children residing in institutions or group settings.

I'd like to introduce Susanne Martinez, on my left, who is the subcommittee counsel.

The purpose of these hearings has been to investigate the scope of this problem, learn about the activities of individuals and public and private agencies attempting to deal with the problem, and, finally, to look at the alternatives on the national level for dealing with this form of child abuse.

To date, the subcommittee has heard the testimony of numerous parents and concerned individuals—from all parts of the country—describing some very shocking and brutal conditions in certain institutions.

An Assistant Attorney General, testifying on behalf of the U.S. Justice Department, at our last hearing in Washington, described the problem of abuse and neglect of children in institutional settings as a "widespread and serious problem."

The Justice Department's representative, and other witnesses, described for the subcommittee some truly atrocious practices.

These practices, verified in judicial proceedings brought against various institutions by Justice Department and private attorneys, have included such things as children being tied, handcuffed, or chained together, or confined to cages as means of control.

Witnesses described institutions where children were tied to furniture, strung up by their arms and legs, in cages, excessively drugged, or left to lie in their own wastes.

We heard testimony of electric cattle prods being used upon institutionalized children as a form of "therapy," as well as physical abuse such as pinching, slapping, force feeding, or withholding of food.

We also learned in our earlier hearings that many of these children are being supported in institutional care by Federal funds.

The Congressional Research Service has estimated that close to $1 billion in Federal money goes into institutions caring for children.

Many of these institutions, of course, provide appropriate and adequate care for the youngsters; some provide very fine care. Many of the individuals involved in this field are humane, caring individuals.

Unfortunately, however, a significant and serious problem exists, and I do not believe we can tolerate continuation—on any scale—of the kind of abuse which we have heard described in these hearings.

Part of the solution, I believe, lies in reducing the number of children who must live in institutions in the first place.

Early next month, I expect to reintroduce in the U.S. Senate, child welfare-foster care reform legislation designed to reduce unnecessary, prolonged foster care placements, encourage the adoption of handicapped children and children with special needs, and provide monitoring and protections for children while they are in the foster care system.

For those children who must have institutional care, there are other steps that I believe the Federal Government can and must take.

Last week, the House of Representatives passed legislation authorizing the Attorney General of the United States to initiate or intervene in legal actions on behalf of institutionalized individuals—including children—whose constitutional or Federal statutory rights are being violated.

I am cosponsoring companion legislation—S. 10—in the Senate with Senator Birch Bayh, and I'll be working toward Senate passage of this legislation—legislation which many of our witnesses have indicated is critical to continued efforts to reduce institutional abuse of children.

I am also undertaking efforts to insure that HEW carry out its responsibility under the Federal Child Abuse Prevention and Treatment Act to deal with the problem of institutional abuse.

As a result of my request at our last hearing, HEW and the Justice Department have agreed to establish an interagency task force to coordinate their activities in the area of institutional abuse of children.

Finally, by conducting hearings such as this and publishing the record of these hearings, I hope to alert the general public and policymakers about the serious problem of institutional abuse of children.

One of our earlier witnesses remarked that if the general public knew what took place in some of the institutions where children reside, they would not tolerate the conditions.

We need to expose these conditions so that changes will take place.

This morning's hearing has three parts:

The first part will focus upon the problem of institutional abuse, both from the perspective of a director of an institution which has been criticized for the quality of care received by the children and from the perspective of a 17-year-old boy who spent 16 years in a Virginia orphanage which has been the subject of litigation by the Children's Defense Fund and is currently under investigation by the State of Virginia.

Then, we will be hearing from representatives of the General Accounting Office, the investigative arm of Congress, on the results of the first stage of an investigation I requested into the reports that a number of foster children who had been placed in facilities operated by the People's Temple, or with members of the People's Temple, had died in Jonestown, Guyana.

My request to the GAO was to investigate these reports, and, if they were true, to provide us with recommendations on any remedial Federal legislative action that should be taken in the context of our effort to reform the existing foster care system.

This morning, the GAO will be providing us with the results of their factual investigation. They will be providing us with their legislative recommendations at a subsequent time.

Finally, we will be hearing from representatives of the State of California and the Los Angeles County Department of Public Social Services, who will be describing the way their respective agencies deal with the problems of abuse and neglect in institutions, and commenting, to the extent they wish, on the results of the GAO investigations.

We will now proceed to our first panel, consisting of Buddy Steele, Director, Glendale Development Center, in Glendale, and Ralph Bak, Director of the Glenridge Center in Glendale, the two institutions that I visited yesterday. If they would please come forward now to the witness table.

I welcome you and appreciate very much your presence.

Mr. Steele. Thank you.

Mr. Bak. Thank you.

Senator Cranston. Do you want to proceed first, Mr. Steele?

STATEMENT OF BUDDY STEELE, PROGRAM SUPERVISOR, GLENDALE DEVELOPMENT CENTER FOR THE HANDICAPPED, GLENDALE, CALIF.; ACCOMPANIED BY RALPH BAK, ADMINISTRATOR, GLENRIDGE CENTER FOR THE HANDICAPPED, GLENDALE, CALIF.

Mr. Steele. I am the program supervisor for the Glendale Development Center for the Handicapped, sometimes referred to as the DCH.

This program for the severely-profoundly handicapped has served the residents of the institution now known as the Glenridge Center since about 1972.

In my capacity as supervisor, I have been in direct contact with many of the residents of Glenridge Center attending the DCH. They range in age from 3 to 21, with a wide variety of disabilities and intellectual impairments. Many of these residents have been in institutions most of their lives.

Glenridge Center is owned by an organization called Catered Living, which owns several institutions for geriatric patients as well as the developmentally disabled.

Catered Living, through a contract with the Department of Health, is licensed to provide care for the residents of Glenridge Center at a reimbursement rate of approximately $37.50 a day—per resident per day.

Catered Living is permitted to earn a profit on this rate, and my understanding is that they have earned a profit each month of their ownership, except one.

The previous owner, Beverly Enterprises, reportedly lost thousands of dollars on Glenridge and sold it to avoid more losses.

I do not understand how it is in the best interests of the human beings living in the institution for the State of California to allow anyone or any organization to earn a profit in providing care for them, particularly when the quality of care is inadequate.

Before I support this contention, I should say that Glenridge students make up 67 percent of our school population, and that I am of the opinion that the quality of care provided for these 68 students is manifested in the conditon in which they come to school.

These conditions, which I and my staff have observed firsthand, are the basis for my belief that something must be done to improve the quality of their lives.

I have divided the kinds of problems I've observed into four large area. (1) Hygiene; (2) safety; (3) clothing; and (4) wheelchairs, seatbelts, and related restraints.

Within this framework, I have attempted to get Glenridge to comply with what I have considered to be basic standards for school attendance.

For example, in the area of safety, I have insisted that students in wheelchairs whose feet do not stay on their wheelchair footrests be restrained so that their feet do not drag on the ground or become caught in the spokes of the wheelchair wheels.

I have insisted that those students who wear diapers wear incontinent pads, called "chucks," on the outside of their diapers, which function like large absorbent pads, so that they do not soil their outer garments or their wheelchair.

I have experienced some resistance to many of these standards, even from the students' social workers, who told me my standards are too high and that I should try to be more understanding of the problems Glenridge was having.

In 1978, I was reporting the following kinds of chronic problems we called "concerns":

Many students with terrible body odor.

Wheelchairs that were without brakes or seatbelts.

Clothing that was either much too small or much too large and often held together by safety pins.

Diapers accidently pinned to the flesh of students.

Safety pins in restraints and bibs.

Students sent to school without the required "chucks."

Students with oily, matted hair.

Students sent to school without required safety helmets.

Parts removed from wheelchairs and lost.

Students wearing other students' clothing, shoes, jackets, et cetera.

Students being sent to school on cold, rainy days without jackets, or jackets that were put on backwards, affording little real warmth.

Long, sharp fingernails and toenails.

Diapers and "chucks" that were so inadequately placed that the students were soaked through to their outer garments.

Wheelchair seat cushions literally soaked with urine.

And old and dried food particles in the cracks and on various portions of the wheelchair.

A great many of these concerns went unanswered and unheeded, even though I reported them repeatedly and often for the same students.

In late 1978, the DCH and Glenridge signed a set of agreements on basic conditions that outlined minimum standards for the Glenridge students attending the DCH. We also signed a set of contingency agreements which were to go into effect if the primary agreements were broken.

When Glenridge disregarded the agreements, I followed the contingency plan and returned students to Glenridge when they did not meet our minimum standards.

The students were not excluded from school, but were returned to be properly prepared for school, as allowed in the Administrative Code, section 302.

This action did not result in an improvement in the students' condition; and, in fact, one student was returned 6 out of 7 days for the same problem each day.

During the period from November of 1978 through January of 1979, I kept extensive notes and documentation on the concerns I was reporting.

I made a chart for each student and found that in that 3-month period, some students were in attendance 64 percent of the time with one or more concerns, and that, on the average, each student attended school more than 30 percent of the time with problems.

As might be expected, Glenridge and the DCH began to view each other as the enemy, the bad guys, or the opposition.

During this time, more and more mistrust came into being between the two staffs, and even today this attitude remains to some degree.

In the meetings that followed, it became clear to me that the Glenridge staff was not the "bad guy." In fact, after a new and more effective director of nurses was hired, and through determined efforts of key Glenridge staff members, improvements have been made.

However, I began to see an emerging picture of why the kids from Glenridge came in such overall poor shape. As the administrator outlined the problem:

Low wages contributed to a poor quality of work from many of the nursing aides.

Low wages also contributed to a high turnover in staff.

Few applicants were available for openings on the staff.

Catered Living reduced the amount of staff on some of the shifts.

The center was being robbed of clothing, diapers, chucks, sheets, et cetera, by their own employees.

Many of the aides did not speak or understand English.

There was no staff person assigned to ongoing care of wheelchairs, for maintenance and cleaning.

The staff "lost" items that were needed by the residents, such as helmets and wheelchair restraints.

The work was hard and unappealing.

And the program is governed by a maze of regulations and licensing rules.

According to Ralph Bak, the bottom line is that the reimbursement rate from the State is not enough to do an adequate job in some areas.

I tend to agree with that assessment.

However, I maintain that no profit should be made on the reimbursement rate. It seems to me all the reimbursement should go to the care of the residents.

The problems experienced in that 3-month period from November of 1978 through January of 1979 have been reduced significantly. However, over the years, I have seen things improve and then deteriorate too many times to get overly optimistic.

Serious problems remain. I still do not feel a bath twice a week for the residents is adequate. It's little wonder that so many students have an offensive odor.

The wheelchairs are not consistently cleaned. We recently discovered maggots living in the cushion of one of the students' wheelchairs.

The students still come dressed in each other's shoes and clothing.

They still come to school with safety pins in their bibs, their clothing, and their restraints.

I feel the wheelchairs will be in serious trouble if CCS stops servicing them or is cut from our program. "CCS" is California Children's Services.

Glenridge sometimes does not have enough "chucks" to send all the kids to school.

Students are still kept home from school for haircuts; and, since November of 1978, we've had 145 absences due to haircuts.

We continue to have conflicts over whether or not I have the authority to send students home when they are not properly prepared for school and whether or not I can insist on minimum requirements.

And, finally, it seems to me the Glenridge residents need an effective advocate, one that will not accept their problems as insurmountable and is unwilling to accept the reasons for their problems as excuses.

Senator CRANSTON. Thank you very, very much.

Mr. Bak, I suggest you go ahead before I ask some questions.

Mr. BAK. May I make some comments on Mr. Steele's statements?

Senator CRANSTON. Yes. I hoped you would.

Mr. BAK. The picture depicted by Mr. Steele gives the impression of very poor, very inadequate care. I don't believe that is a true and accurate picture of the care being provided by Glenridge.

The care is not the best in the world; but, in terms of sufficiency and adequacy, by and large, it is sufficient; it is adequate.

And, in terms of quality, I feel it's anywhere from good to excellent. There are exceptions, because of the fact that we can't guarantee that every single moment of every single day a resident will go to school perfectly groomed, bathed daily. We don't have the funding, nor the staff, to be able to provide that sort of care.

But every effort is made to send the children to school adequately dressed. There are times when the weather might be inclement, and the person in charge of preparing the children for school might not feel that—or may not have felt that extra outer garments were appropriate on that particular occasion.

So there are errors and mistakes made—honest errors and mistakes made—in the provision of care. But, there is never any deliberate attempt to shortchange care.

I, myself—along with Betty Carrington, who is an LVN, who has been working at Glenridge for the past 10 years; and Mr. Joe Murphy, who is our special-treatment program director, who has been associated with Glenridge the past year; and there are many other individuals who are not present here. I believe there should have been a representative of our parents' association here this morning; I hope she is here—would be able to vouch for the fact that, while the care is not perfect, it is good—darned good.

There are a lot of people who risk their necks to provide loving, tender care to these handicapped children; and, by and large, I believe we succeed.

In terms of the care, other individuals might see our problems from a different point of view. But, I definitely and emphatically and strongy disagree that our wards or our charges are in any way abused or shortchanged because of lack of concern on the part of staff for their care.

I also disagree with the contention that Mr. Steele made in his statement that it is somehow wrong to profit from the care of these children. There is an investment made in their care by the operator, and the operator definitely, in keeping with the free-enterprise system, does have a right to reasonable return on their investment.

I'd like to continue now with my prepared statement.

Senator **Cranston**. I think he was saying on the profit matter, that you should not make a profit from any additional public funds that come in to you; I don't think he challenged the right to make a profit overall, taking all sources of revenue into account.

Isn't that correct, Mr. Steele?

Mr. **Steele**. That's right.

Senator **Cranston**. All right.

Mr. **Bak**. I understood his statement to be just the opposite, Senator. I don't believe we should get into that issue, though.

My statement is the "Underfunding of the Care of the Developmentally Disabled as Child Abuse."

Senator Cranston and members of the Senate Subcommittee on Child and Human Development, my name is Ralph Bak, and I am the administrator of Glenridge Center for the Handicapped, located at 611 South Central Avenue in the city of Glendale.

I have held that position for the past 2 years. Glenridge is licensed by the State of California as a skilled nursing facility certified to provide both nursing and rehabilitation services to the severely/profoundly retarded and physically handicapped.

Since the scope of the subcommittee's hearings, both here and elsewhere, is to look into instances of child abuse/neglect in order to offer legislative solutions to same, I have sought this opportunity to present my views on what I consider a most serious and insidious form of child abuse that largely goes ignored by legislators at both the State and Federal levels of government, but particularly by those functionaries in Government whose responsibility it is to formulate and fund programs such as the Federal ICF-MD and California ICF-DD regulations.

What I am referring to is the tragic underfunding of those programs here in California that handicaps those of us who must try to implement those programs and deprives the residents of a facility such as Glenridge Center of the kinds of services they need and which would contribute enormously to maximize their capabilities and potential, however at times limited that may be.

The operators and staff of Glenridge Center, both former and present, have expended large sums, and continue to do so, in an honest effort to provide the best possible care to these unfortunate victims of birth defects.

However, while care of the clients entrusted to the Glenridge staff continues to be, as a rule, good to excellent, in spite of underfunding, there are many services, particularly physical and occupational therapy, that we provide too little of to our clients, due to financial constraints placed on us by reimbursement formulas that are unrealistically low and downright inadequate to do the job we are called on to perform.

Underfunding of DD programs by the State has resulted in either enormous losses to the facility operators and/or a reduction of services to the clients served.

Beverly Enterprises, which operated Glenridge Center from early 1976 until July 1, 1978, lost almost $290,000 in that time on that one facility alone, not including $50,000 in capital improvements.

Low census partially explains some of the horrendous losses of those years; but it does not explain away all of those financial deficits.

The fact that Glenridge has operated in the black, with the exception of 2 months, since the takeover last July 1, 1978, by Catered Living, does not change the fact that, in my opinion, the California reimbursement rate provided by MediCal for the care of the severely/profoundly retarded is not adequate to pay for the cost of same.

Incidentally, it is not $37, as Mr. Steele stated. We are presently receiving a reimbursement rate of $33.24.

It permits a profit to the operators of Glenridge at the expense of the nursing attendants and other low-paid ancillary staff who work for wages that average $1 less per hour than identical work performed by employees in State hospitals or in an acute hospital setting or in most private industry.

Catered Living, Inc., the operators of Glenridge, turned a money loser into a money winner because they, very correctly, did not feel obligated to subsidize the California mental health program as Beverly Enterprises had done.

The ones who ultimately subsidize that program and make it work are the underpaid employees and the residents of Glenridge who don't get services they desperately need.

It is my contention that politicians pay greater heed to demands for decent wages for farmworkers than they do to support an adequate wage for nursing attendants responsible for the health and safety, care and comfort, the very lives of crippled human beings.

Our society is willing to pay more for a head of cabbage than to pay well to have a human being bathed and clothed and fed and loved.

A number of our employees are compelled to work two jobs in order to make ends meet, to support a family. The low pay scale inevitably results in some instances of a few poorly motivated staff occasionally giving poor care.

This is the exception, rather than the rule; for every effort is made to weed out unsuitable staff or those who are deliberately careless and slovenly in their work.

By and large, the care provided by our staff ranges in quality from good to excellent. And I have never personally seen or known of any intentional malicious act of physical or mental abuse committed against our residents.

Their care involves a considerable amount of very hard, unpleasant work. Almost 90 percent of the residents of Glenridge require total care; they are incontinent, soiling and wetting themselves several times each day, both during sleep and waking hours.

Almost 80 percent must be fed or depend on some assistance when eating.

Almost 90 percent either cannot clothe themselves—the majority—or require considerable assistance in doing so.

The low-functioning level of most of our residents makes them largely untrainable.

However, they are not completely devoid of some limited potential to be trained in the basic ADL—activities of daily living—skills of toilet training, self-feeding, and dressing and grooming—and considerable efforts are made to train them in those skills.

Much effort is also devoted to prevent contractures by physical therapy; to ambulate them; to teach them to crawl or walk. Occupational therapy serves to enhance the quality of life for them by providing them with the sensory stimulation of music, touch, games, and similar activities to provide both physical and mental stimulation and training in gross and fine motor skills.

State funding permits us to employ professional occupational and physical therapists for only several hours each week, preventing us from doing as much for our residents as they need done for them.

About all these professionals can do for our residents is to measure their disabilities and instruct staff in the provision of rudimentary physical and occupational therapy.

To improve the level of care required of us in providing services to the developmentally disabled, I recommend that the State, for a facility such as Glenridge, provide funds for:

(1) A starting rate of pay of $4 per hour for nursing attendants, based on a 40-hour workweek.

(2) Full-time physical and occupational therapists.

(3) Funding for sufficient support staff to insure the provision of nursing and ancillary services of suitable quality. Specifically, this means the funding necessary to allow us to employ a full-time nursing supervisor on our p.m. shift, an extra maintenance person to do necessary and routine maintenance of equipment and physical plant to prevent deterioration of same that occurs so easily and quickly in a facility where residents are hard on same.

(4) To fund at a realistic level the in-house training program for direct-care staff, which averages $20 per day as against our cost of $50 per day.

I have estimated the total cost of all these additional services to be approximately $1,000 a day, necessitating an increase in the reimbursement rate to us from $35 per patient-day to $45.

As I mentioned, we are presently receiving $32—$32.24. That's based on the fact that we have been certified for what the State refers to as "range A" staffing, rather than being reimbursed for "range B" staffing, which we are presently providing, which calls for a reimbursement rate of $35.47.

I recommend an increase of the reimbursement rate to us from $35 per patient-day to $45.

This, however, is far less than the approximately $100 per day cost for the care of a DD client in a State hospital, and I got that figure from a staff person at Lanterman State Hospital, so that would apply specifically to that particular hospital. This person, I believe, was in a position to know what their costs are per patient-day.

And our reimbursement is less than the $60 per day paid by a combination of State agencies for board and care in a residential facility for the moderately retarded.

What I'm asking for may seem like a lot of money, and perhaps it is; but there are not that many DD facilities in California serving the severely, profoundly retarded.

Statewide, the program would not cost more than $5 or $6 million over and above the present cost of same.

My data are not what you would get from a CPA, but the rough calculations of someone involved directly with the care of the developmentally disabled whose primary concern is care rather than cost.

I realize we cannot go overboard on cost; but, had the State budget people not scuttled what the health department rates and fees people had recommended in terms of reimbursement based on level-of-care requirements, the total overall cost of the State ICF-DD program would not have to be increased by as much as the $5 or $6 million I suggested.

Now, as an aside to my main issue of the underfunding of the care of the developmentally disabled, in my work I see another form of child abuse perpetrated by parents and well-meaning social workers, and that is the unnecessary, premature institutionalizing of many children under 5 years of age not requiring special medical services; and, of a fair number of those between 5 and 10 years of age.

I feel that we try to spare families the embarrassment of a defective child, even during those years when such a child is still almost an infant and relatively easy to care for, when care at home would be far better than the care it would receive in an institutional setting.

This is the end of my statement, Senator.

Senator **Cranston**. Thank you very much.

Mr. Steele, do you have any comments on Mr. Bak's testimony?

Mr. **Steele**. I'd like to say that I agree with a lot of what Mr. Bak said. I don't believe that I've ever known of or heard of any type of abuse perpetrated by any of the staff members. It's not that kind of facility.

The kinds of problems that have come up, I feel that if I was the administrator of that facility, I doubt that I could do anything more than he's done or that the staff has done.

So that the kinds of problems that I've outlined, I really don't see a solution with the system the way it's now set up.

Senator CRANSTON. So you think it's mainly a funding problem?

Mr. STEELE. That's what I think.

You know, when you look at how many, the amount of work each of their staff persons has to do, the difficulty of it, it's—you're going to have problems. You're always going to have problems.

Senator CRANSTON. Do you feel there is also inadequate monitoring? For example, did you feel that during the time you were actively monitoring the condition of the children when they arrived, that there was an improvement?

Mr. STEELE. I didn't feel there was an improvement until they got a new director of nursing who was a good employee. She worked very hard.

A lot of the people on the staff worked hard. But I think that that depends on if you have a very resourceful staff person in a key position, and they're fortunate to have that. If they didn't have that sort of person, I really don't see how they could meet the standards that we require.

Senator CRANSTON. Have you had much interaction with the parents of children over the conditions at Glenridge?

Mr. STEELE. Not with the parents of Glenridge; no.

Senator CRANSTON. How does it happen you haven't?

Mr. STEELE. I'm sorry?

Senator CRANSTON. How does it happen you haven't had any interaction with the parents?

Mr. STEELE. Well, I think that in many instances the parents are not as involved in their school program as they may be in their institutional program.

There's a similar—they have an educational component to their program at Glenridge, and——

Senator CRANSTON. Well, I meant in regard to the conditions at Glenridge, why you haven't had any discussions with the parents.

Mr. STEELE. Well, I haven't had contact with them. My contact has primarily been with the institution. I felt that that was the appropriate approach.

Senator CRANSTON. What do you think the Federal Government can or should do about the problem?

Mr. STEELE. Well, I'm not sure what the Federal Government should do about it; and I know the easy solution is to always ask for more money.

I really don't feel prepared to offer a solution. All I really feel that I can do is describe what I've seen since 1972. And I'm really not sure what the Federal Government could do.

Senator CRANSTON. Mr. Bak, how would you explain the existence of maggots in a wheelchair, and the improper clothing that apparently has occurred, and the lack of cleanliness?

Mr. BAK. With regard to the case of the maggots, we had a couple of instances of that just recently due to food particles being caught in crevices of a wheelchair and the wheelchairs being soaked; the humidity together with the fly situation, which is not bad; but I feel that that's what created the maggot situation.

We tried to remedy it as quickly as possible, as soon as we became aware of that.

The clothing situation, the residents of Glenridge receive SSI funds of $25 a month, which has to pay for a monthly laundry charge of $10; and the balance is used for their clothes.

So they have limited funds to purchase clothing with. We generally purchase clothing for the residents three or four times a year with whatever funds they do have available for purchase of same.

Many of the residents are growing; so they outgrow their clothes very rapidly.

Due to the fact that they are incontinent, there's a constant need to launder the clothes, which causes clothing to be worn out very quickly.

They have to be sent to school with, generally, double-diapers and one of these disposable "chucks" over that; and, very often, that results in a very poor fit, particularly the pants over that amount of undergarments.

Senator CRANSTON. How many residents are there?

Mr. BAK. We have presently a census of 112.

Senator CRANSTON. How many employees?

Mr. BAK. We have a total on all three shifts, all departments, of approximately 100 employees. This is both professional and nonprofessional staff.

Senator CRANSTON. What is the age span of the residents?

Mr. BAK. The average age is approximately 30.

Senator CRANSTON. What is the average length of stay?

Mr. BAK. The average length of stay is—they're permanent residents.

Senator CRANSTON. Do you have much staff turnover?

Mr. BAK. A certain amount. But far less than the working conditions would really indicate.

Particularly within the first 30 days after hire, we have a fairly large amount of turnover. If anybody lasts more than 30 days, they usually stay quite a long time.

We have quite a number of staff who have been there anywhere from 6 months to several years. We just had one staff person retire at age 62 who had worked at Glenridge for approximately 10 years.

Senator CRANSTON. How long has Glenridge been in existence?

Mr. BAK. Glenridge was established as a geriatric facility back in 1964 by the original owners. It became a DD facility several years ago.

I haven't been associated with it that long to really know the exact time when the transition took place. But, I would say approximately 5 or 6 years.

Ms. Carrington, our LVN, who is here, probably would be able to answer that question more accurately than I could.

Senator CRANSTON. If you consider most of the residents permanent residents, I noticed yesterday that most of them are very young; will you have an older population as time goes on?

Mr. BAK. Generally, when they reach, say, into their fifties, they're then at that time or at that point more suitable for a geriatric facility; and we, within the past year, discharged three or four older residents to geriatric facilities.

Senator CRANSTON. Do you receive funds other than public funds?

Mr. BAK. No.

Senator **Cranston**. Well, then, that gets around to the question of from where the profit would come. Mr. Steele, were you referring to new funds should not be used for profit? Because they are in a profit-making business, rather obviously.

Mr. **Steele**. What I was referring to was the fact that—and this is my opinion—that the State should have a system that they could provide the same service without providing anybody a profit; the same service that Catered Living provides. They are supposed to provide certain things, and they do within the legal minimum.

Senator **Cranston**. Do you think the State should be running these institutions, rather than having institutions like Glenridge that are privately operated for profit?

Mr. **Steele**. If the cost is $100 a day, no.

I think the State should have a system, and, if that requires the State to do it, that might be the best idea.

Senator **Cranston**. Do you think the State should only be funding nonprofit institutions?

Mr. **Steele**. Yes.

Senator **Cranston**. You indicated, Mr. Bak, that the new owners of Glenridge have been operating in the black since they took over. What steps did you take in order to begin making a profit?

Mr. **Bak**. Back in July of last year, we had to reduce staffing somewhat. The other step that was taken was to reduce the employees' workday from 8 hours a day to 7.5 hours per day; and those two steps resulted in the turnaround.

Senator **Cranston**. What type of profit are you now making?

Mr. **Bak**. It's varied. The average is approximately $5,000 a month, which is—I don't know exactly what sort of investment the company has made; I'm not privy to those figures.

But I would say that figure is a modest return, considering the number of residents we have, the amount of investment, the equity, and the general overall income, gross income per month.

Senator **Cranston**. You mentioned—very appropriately—that the people who subsidize institutional care, when the State or Federal Government doesn't provide adequate reimbursement rates, are the underpaid employees and the residents of Glenridge who don't get the services that they need.

Mr. **Bak**. Correct.

Senator **Cranston**. If the reimbursement rates were increased to the level that you suggest, would you be able to increase the pay of your present staff, or add staff, so that patients would get better services?

Mr. **Bak**. Very definitely.

Senator **Cranston**. You mentioned an important issue: The unnecessary, premature institutionalization of many children under the age of 5, and a fair number of them between 5 and 10 years of age, for whom care at home would be better than what they can receive in an institution. How many children at your institution could be cared for at home, in your opinion.

Mr. **Bak**. I would say four or five that I can think of. There are probably, maybe if we looked at it more closely, a few more than that.

But I've seen instances where we've had a certain turnover in placements where the children were taken back home, and they are thriving at home; they really didn't need to be institutionalized.

Senator **Cranston**. You have commented on Mr. Steele's expression of concerns about the quality of care at Glenridge; what part of his criticisms or comments have validity, in your opinion?

Mr. **Bak**. He and I have both worked very closely together to try to remedy the problems that arise in terms of the way the children arrive at school, and I think Buddy and I have had a fairly good rapport.

The validity is 100 percent in terms of the particular instances. But, it's the overall picture that I have to disagree with.

Because, while there are many instances of inadequate care, he agreed that there is never a case of deliberate abuse.

The fact that some of the children go to school in poor- or ill-fitting clothes, the bibs become torn and do have to be sometimes fastened with—instead of a string, the tie string or the snap, sometimes staff resort to using a safety pin to attach a bib; and that, by itself, does not indicate poor quality of care.

As a rule, we bathe the residents twice a week, unless they require extra bathing due to the fact that they've soiled themselves.

There's another point that needs to be made. Our type of resident is not very cooperative in his own care; and, particularly with the larger residents, it's very difficult to give them a good bath.

When somebody is struggling and he or she is almost bigger than you are, and where they are nonambulatory and have to be wheeled in a shower chair to the shower and are struggling against being given a bath, the bathing sometimes leaves something to be desired. Not in every case, but there are instances of that.

If there are any instances of abuse, I would say it's abuse of staff by residents, where staff are bitten, kicked, or punched by residents; and it's never happened the other way around.

So, the staff workload is extremely difficult, particularly, as I mentioned yesterday to you, on the p.m. shift where the bulk of the baths are given; and what results is usually less-than-perfect care. But it's never deliberately done to shortchange the resident on what he is entitled to and what the State is paying for.

The fact is, by and large, the State is getting a real bargain. The State is getting $100 worth of care for $33.

Senator **Cranston**. Mr. Steele thinks that conditions improved when you acquired a new director of nursing. Do you agree with that; and, if so, doesn't it indicate that there is room for improvement, despite the funding constraints?

Mr. **Bak**. With regard to the specific individual, I have to disagree with that; because the basic staff does the care. Who the director of nursing is, is not a particularly important matter or issue with the quality of care.

Most of the staff have been there for a good long time. Directors and administrators come and go. And the quality of the care has been relatively good, regardless of who's at the very top.

As I mentioned earlier, Ms. Carrington had been at the facility for almost 10 years; and she's seen many people come and go.

But she's a person who's dedicated to the care of the residents at Glenridge; and it's people like her and the other members of the staff who really provide the care, rather than the administrator or the director of nursing.

Senator Cranston. Thank you both very much. I appreciate very much your coming and your helpfulness.

Mr. Steele. Thank you.

Mr. Bak. Thank you.

Senator Cranston. We are now going to hear from Johnny Dotson, a former resident of Mountain Mission School in Grundy, Va.

I appreciate very much your getting in touch with us and your willingness to come and testify.

Mr. Dotson. Well, I'm glad to be here.

STATEMENT OF JOHNNY J. DOTSON, FORMER RESIDENT OF MOUNTAIN MISSION SCHOOL, GRUNDY, VA., ACCOMPANIED BY DANIEL BLOCH

Mr. Dotson. My name is Johnny Dotson. I'm a former resident of an institution called the Mountain Mission School. I was sent there when I was about 2 or 3 months old, along with my brothers and two sisters; and I've lived there for 16 years.

At the age of 10 months old, I was allowed to drop from the third-story window. And, while there, I witnessed children being handcuffed to beds; tied to chairs; lice; lack of medical care; lack of good food; people being beaten and brutally abused by the authorities.

The authorities were opening mail and stealing money from the kids, and people were just running away and talking; and the authorties would bring them back and chain them and make sure that they would not complain to anyone else.

When I was 12 years old, I met Mr. Bloch here, who is to the left of me, and he helped me find a judge in Clearwater, Fla., who I talked to at the age of 12 and complained; and he granted my custody to Mr. Bloch.

Well, a week after my custody was granted to him, the FBI picked us up, locked me and the other boy whom he helped also, locked us up for a week; and the institution that we had originally came from falsely charged him of abducting me and the other boy whose name was Robert Watts.

And they sent me back to the institution, to be suborned to perjury. I was beaten later. I've seen other kids beaten to tell lies and not to tell the truth in court.

And Robert Watts was moved to five other different foster families immediately after they found out that he had contacted Mr. Bloch and the ACLU to help him contact his real mother and his original family.

The Government officials who we talked to have said that they were going to do some thing about it; but they haven't done anything yet. And they have tried and tried to suppress us from coming out with the truth and to have this institution corrected.

That covers it, just about.

Senator Cranston. What are you doing now; you are away from the institution now?

Mr. Dotson. Correct.

Senator Cranston. When did you leave there?

Mr. DOTSON. When I was 15 years old, the authorities sent me away, in fear that I would talk to the people locally and have the place inspected.

The Virginia Legislature passed a law saying that this institution is exempt from the welfare laws. They are not licensed by the State or anything like that.

When I was 15, they tried to send me to Montana and to Colorado, which is pretty far from Virginia, to get me lost so that I would not be in contact with any of my relatives or anybody that would help me do something about these people at the institution.

Senator CRANSTON. What are you doing now?

Mr. DOTSON. Now I am filing suit against the Mountain Mission School, against the State of Virginia, against the State of Ohio.

The welfare department of Ohio has illegally sent 16 or 17 kids out of State to the institution in Virginia.

Senator CRANSTON. You've obviously waged a real long struggle to get people to listen to you and be aware of the facts that you have witnessed, and you've been trying hard to get action taken to deal with these injustices; do you think the social service people and the ACLU and the welfare agencies and the FBI and the many other authorities and agencies you contacted were unsympathetic or just couldn't believe what you were saying?

Mr. DOTSON. Well, the people that we have talked to in Washington were quite sympathetic.

But the FBI department in Sarasota, Fla., and in Virginia were rude to us. They were in a hurry to get us out of the office and telling us what we should say; instead of what we had to say, what was supposed to have been said.

Senator CRANSTON. If a Florida judge had been involved in the action that got you out of the institution, why did the FBI come in and take counteraction?

Mr. DOTSON. The FBI, we showed them the papers that the judge had given my custody to Mr. Bloch. They did not believe that. They tried to suppress me from talking and from coming out with the truth.

Senator CRANSTON. What do you think needs doing generally—not just in your case—but to deal with this kind of situation?

Mr. DOTSON. I think, personally, that orphanages and instituions need to be closed down. There are kinds—there are people who are paying $20,000 under the table for a kid. And these institutions—well, from what I have experienced—are for the authorities and not for the children.

The authorities will not let children be adopted. I have seen it. I've seen families come in and say, "I want this kid. I want this family. I want to adopt them." But the authorities will not let them be adopted.

Senator CRANSTON. Because they want to keep them under their control and——

Mr. DOTSON. They do.

Senator CRANSTON [continuing]. Make a profit off them?

Mr. DOTSON. They do. The institution from which I came from had at least 50 children there who were collecting social security benefits from deceased parents; but, this school, the authorities there were taking in the money, saying that they were using them for the funds of the school.

But the kids didn't get but 37 cents a meal, per meal, three meals a day.

Senator CRANSTON. Is the Mountain Mission School still operating?

Mr. DOTSON. Yes; it is.

Senator CRANSTON. And just as bad as ever, as far as you know?

Mr. DOTSON. Yes.

They are still trying to suppress us from coming out with the truth.

Senator CRANSTON. What agencies did you contact in your efforts in this regard?

Mr. DOTSON. We have contacted Senator Stone, Representative Ireland.

We've contacted your office, which is why we're here now.

We've contacted the ACLU. We've contacted the Justice Department; and Vice President Mondale's office, we've talked to his people; and to the Children's Defense Fund.

Senator CRANSTON. What response have you gotten, generally, when you contacted them?

Mr. DOTSON. Well, they were very sympathetic and warm, and listened; but, we haven't seen anything done yet.

The U.S. attorney from Roanoke, Va., we contacted him because the U.S. attorney from Richmond told us that we were to contact him. So when we contacted the U.S. attorney in Roanoke, they said that they couldn't do anything unless they had sufficient information from the FBI agency in Bristol, Va., whom we contacted, who said that they could not do anything unless they had orders from the U.S. Attorney in Roanoke.

Senator CRANSTON. Is the Virginia attorney general looking into this?

Mr. DOTSON. As far as we know, yes.

Senator CRANSTON. As I mentioned earlier today, there is legislation I'm working on with Senator Bayh that would give the U.S. Attorney General power to get into the act and bring legal actions against institutions which abuse children and that may be one remedy.

Have you talked to a number of other boys and girls from other institutions as to their experiences?

Mr. DOTSON. Yes.

Senator CRANSTON. Do you feel there are a number of other places like Mountain Mission School?

Mr. DOTSON. Yes.

I have visited some of them. I have seen pretty-similar to what I have experienced in the institution that I've lived in.

Senator CRANSTON. How did you go about visiting other institutions?

Mr. DOTSON. Through churches. Through vacations. And just other institutions getting together and, as a child, as children wanting to associate with each other.

Senator CRANSTON. What are your own plans and ambitions? What do you hope to do in the future?

Mr. DOTSON. Well, I hope to close down as many institutions as I can.

Senator **Cranston**. What would you substitute for those institutions? If you close down Mountain Mission School, where do you think the kids should go that are there?

Mr. **Dotson**. To foster parents; or back, in most cases, back to their original parents.

Senator **Cranston**. I'm also working on legislation designed to make it easier for children to be adopted and to remove some of the barriers. There are other barriers beyond those you talk about.

There are barriers such as I mentioned earlier this morning; for example, a child that is handicapped or needs special help can get aid in foster care but loses that aid if he is adopted.

Mr. **Dotson**. Right.

Senator **Cranston**. And we have to, obviously, remedy problems like that.

Mr. Bloch, do you have anything to add?

Mr. **Bloch**. I don't think you have enough time for me to comment, sir. I think Johnny's written statement, which has been submitted to you and copies of which are available to the press, cover it adequately.

Senator **Cranston**. Are you working with Johnny in this effort?

Mr. **Bloch**. Yes, sir.

Senator **Cranston**. He is not in your custody now?

Mr. **Bloch**. Yes; he is.

Senator **Cranston**. He is?

Mr. **Bloch**. Yes.

Senator **Cranston**. Then, you are his guardian?

Mr. **Bloch**. Yes, sir.

Senator **Cranston**. Well, I have great admiration, from my understanding of what you have been doing.

Mr. **Bloch**. Thank you, sir.

Senator **Cranston**. And, Johnny, you're great to have reacted as you have and to be as courageous and as determined as you are.

Mr. **Dotson**. Why, thank you.

Senator **Cranston**. I'm very glad you got in touch with me. We will be doing what we can on the Federal level to deal with these kinds of institutions.

You have an opportunity, from your background and understanding, to do a lot of good for people; and I urge you to keep it up, and I congratulate you.

Mr. **Dotson**. Thank you.

Senator **Cranston**. Thank you a great, great deal.

Mr. **Dotson**. Thank you, sir.

Mr. **Bloch**. Thank you very much.

[The prepared statement of Mr. Dotson follows:]

Senator CRANSTON. We will now hear from Franklin A. Curtis, Associate Director of the Human Resources Division of the U.S. General Accounting Office. Thank you very much for being with us.

STATEMENTS OF FRANKLIN A. CURTIS, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY MESSRS. BENEDETTO QUATTROCIOCCHI, RICHARD NEUMAN, JIMMY L. BOWDEN AND SCOTT SORENSEN

Mr. CURTIS. Thank you, sir.

Let me first introduce my colleagues with me this morning. On my right is Mr. Bowden, and next to him is Mr. Sorensen, who are with our Los Angeles regional office; and on my left is Mr. Quattrociocchi and Mr. Neuman, who are with the Human Resources Division in Washington, D.C.

My statement, Mr. Chairman, is a little long, and with your permission, I will briefly summarize it and hope that you would then include it for the record in its entirety.

Senator CRANSTON. Yes; that will be the way we will proceed; and I appreciate that approach.

Mr. CURTIS. Mr. Chairman, I am pleased to be here today to discuss the placement of foster-care children with Peoples Temple members and their emigration to Jonestown, Guyana.

Last February, you requested us to review the placement of foster children with Peoples Temple members.

Today, I will be primarily discussing factual data that we have obtained in the initial phases of our review. We are continuing our review and plan to provide the subcommittee with a report on the results later this year.

Reverend Jones initiated action towards establishing an agricultural development community in Guyana in late 1973, and Temple member emigrations to Guyana began in early 1977.

On November 18, 1978, the tragedy at Jonestown occurred. Of the 913 people who died there, about one-third were under 19 years of age.

We conducted our work at the U.S. Department of State in Washington, D.C., the California Department of Social Services, and 13 counties in California. About 74 percent of California's 25,000 foster-care children reside in the 13 counties where we made our review.

From two U.S. Department of State lists of verified and unverified Peoples Temple members who died in Guyana and a listing compiled by a Peoples Temple attorney of all the persons who emigrated to Jonestown from the San Francisco area, we identified 337 children who were in Guyana at the time of the tragedy.

All of the names of the Peoples Temple members who emigrated to Guyana were checked against the State's Medi-Cal historical files.

In addition, we subpenaed and examined county welfare records of the children that were identified in the review of the Medi-Cal files. With the assistance of State and county officials, we identified the children that had a welfare history and reviewed the available case files for these children.

Title IV-A of the Social Security Act makes Federal matching funds available to the States under the aid to families with dependent children program for foster home care of dependent children.

The Federal Government also contributes to the support of foster children through title IV-B and title XX of the Social Security Act.

These programs provide Federal matching funds to support child welfare services and social services to adults and children.

The total State and Federal title IV-A, IV-B, and XX funds allocated for foster care was almost $1.2 billion for fiscal year 1977. This was the latest year for which this information is available.

The State of California Department of Social Services has overall responsibility for administering the State's foster care program for children.

However, the individual counties operate their own foster care systems.

In fiscal year 1978, California spent $46.3 million of Federal funds authorized under titles IV-A and XX, and $121.5 million of State and county funds for its foster care program. The State did not spend any of its title IV-B funds for foster care.

Children enter foster care in one of two ways—by a court directing placement because of the child's behavior and/or home situation, or by the parents voluntarily allowing a placing agency to place the child outside the home.

Federal law makes a judicial determination a condition for AFDC foster care eligibility.

Each foster-care child, under Federal funding, must have a case plan and a redetermination of Federal eligibility must be accomplished every 6 months. There are no Federal regulations requiring visits by welfare caseworkers to foster children.

Of the more than 900 Temple members who emigrated to or were born in Guyana, we identified 337 children who were under 19 years of age at the time of the tragedy.

Of the children identified, we were able to determine that 248 had a prior welfare history. Of 223 children in cash-grant programs, 204 were previously in the aid to families with dependent children program. Three were previously in the federally-supported foster care program, and 16 were previously in the foster care program funded solely by the State and counties.

Of the 19 foster-care children who emigrated to Guyana, 16 children have been reported as perished, 2 have been reported as surviving, and the status of 1 child has not been resolved.

Of the 19 foster-care children who emigrated to Guyana, 12 had been placed with Peoples Temple members.

We have attached to our prepared statement a case profile for each of the 19 children who were in a foster-care status at some time prior to their emigration to Guyana.

Twelve of the children were females and seven were males. Sixteen were black and three were Caucasian.

Two were from 5 to 7 years old. Four were from 8 to 10 years old. Six were from 11 to 13 years old. Six were from 14 to 16 years old. And one was over 18 years old.

At the time of departure for Guyana, four of the children had been reunited with and were accompanied by one or both of their parents, or a relative; six had been living with a relative but were not accompanied by a relative; two were accompanied by their adoptive mother; two were accompanied by their legal guardians; two had a legal guardian but did not depart with the guardian; and one had been adopted but did not depart with the adoptive parents.

We were unable to determine the family status or departure circumstances for two of the children.

Also, information was not available which showed who accompanied the nine children who were under the custody of but were not accompanied by their relatives, guardians, or adoptive parents.

Only 1 of the 19 children was still in foster care at the time of departure to Guyana. Three had terminated from foster care less than 4 months prior to departure; four, from 4 months to 1 year; three, from 1 to 1½ years; one, from 1½ to 2 years; six, from 4 to 5 years; and, one, over 6 years.

With regard to the one child who was continued in paid foster care, payments of $150 a month from May through November, 1977, or a total of $1,050, were made to her foster parent, who remained in California after she went to Guyana.

In March, 1979, the State determined that the payments were not allowable.

Of the 337 children who emigrated to Guyana, 31 were or had been under guardianship of Peoples Temple members. Included in the 31 were 9 children who had been in foster care.

In the early 1970's children were being placed in unlicensed homes of Peoples Temple members in Mendocino County by placement agencies in other California counties.

Mendocino County officials raised objections to the counties because this practice was contrary to State and county regulations which required that foster children be placed in licensed facilities.

During the same period, Peoples Temple attorneys and members began filing petitions for guardianship of children for Peoples Temple members.

Under the guardianship arrangement, children were placed in Temple members' homes, which were exempted from the licensing requirement, and the children were not under the jurisdiction of the Department of Social Services.

In our review, we found that nine of the foster children were or had been under guardianship arrangements with members of the Peoples Temple.

The guardians of seven of the nine children received foster care payments for the care of these children.

However, only one of the guardians that received foster care payments had a foster home license.

State regulations require an evaluation of unlicensed guardian homes to assess whether the social and psychological needs of the child are being met.

In our ongoing review, we plan to obtain additional information on these evaluations.

We asked a judge of the probate department of the California Superior Court to provide us with legal references and to clarify the issue of whether a guardian may change the minor's domicile outside the State without prior court approval.

He advised us, informally, that he is not aware of any California statutory requirement that a guardian must obtain a court approval for a change of the minor's domicile outside the State, except in situations where a child is a ward of the court placed through the court's probation department.

We have undertaken legal research in an attempt to determine the legal requirements regarding this issue.

We noted that in two of the nine foster care/guardianship cases, the guardians had obtained court approval to take their wards to Guyana.

Payments to the foster-care parents of the 19 children who spent some time in foster care totaled about $75,000 for the total time period that the children were in foster care, including $50,000 paid to foster parents associated with the Peoples Temple.

About $5,800 of the $75,000 was provided from title IV–A funds for the three federally funded foster care children.

We coordinated our review with the offices of the HEW Inspector General, the State of California Department of Social Services and Welfare Fraud Investigation and Prevention Bureau, and the welfare agencies in the counties.

The initial Inspector General's review objective was to follow up on any improper Federal foster-care payments made to Peoples Temple members, relying primarily on the work performed in GAO's analysis of the individual case files.

Their subsequent review is to be directed toward the Federal, State, and county monitoring of the foster care program in California.

As part of its monitoring review, the Inspector General plans to determine which actions have been taken on the recommendations contained in our report entitled, "Children in Foster Care Institutions: Steps Government Can Take To Improve Their Care."

Also, payments made to Peoples Temple members are being investigated by the Social Security Administration.

The State's investigative efforts primarily have been directed toward determining whether improper AFDC and foster-care payments have been made.

As of March 1979, the State had identified 17 AFDC cases where payments were made to families after one or more of the family members had moved to Guyana.

The State estimates that the overpayments in these 17 cases will amount to about $20,000.

Some of the county welfare departments performed independent reviews of their computer files. These reviews did not identify any additional children with foster-care histories beyond the 19 foster children previously discussed.

Mr. Chairman, that concludes our statement, and we would be happy to answer any questions you may have.

Senator CRANSTON. Thank you very much for a very concise, succinct summary of your longer statement; and I want to thank you and the GAO very much for the very fine and, I gather, very effective study that you've made.

[The prepared statement of Franklin A. Curtis follows:]

United States General Accounting Office

Washington, D.C. 20548

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Statement of
Franklin A. Curtis, Associate Director
Human Resources Division
Before the
Subcommittee on Child and Human Development,
Committee on Labor and Human Resources
United States Senate
on
Placement of Foster Care Children
With Members of the Peoples Temple

Mr. Chairman, I am pleased to appear here today to discuss the placement of foster care children with Peoples Temple members and their emigration to Jonestown, Guyana.

Last February, you requested us to review the placement of foster children with Peoples Temple members and to determine:

--the extent and circumstances of such placements,

--the amount of Federal funds utilized for the placement and/or support of these children,

--the circumstances under which foster children were removed from the United States to Guyana,

--whether any foster children died in Jonestown, and

--whether any Federal funds were diverted from their statutory purpose.

Today, I will be primarily discussing factual data that we have obtained in the initial phases of our review of the placement of foster children with members of the Peoples Temple.

We are continuing our review of the State, Federal, and county responsibilities for the administration of the foster care program in California including guardianship activities and plan to provide the Subcommittee with a report on the results later this year.

PEOPLES TEMPLE

Since the tragedy at Jonestown, much has been written about the beginning, growth, and demise of the Peoples Temple and its leader, Reverend James Jones, Sr. Briefly, Reverend Jones started his own church in Indiana in the 1950s. In the early 1960s, his church, now referred to as the Peoples Temple, was listed as affiliated with the Christian Church (Disciples of Christ). In the mid-1960s, an envisioned nuclear holocaust prompted Reverend Jones to settle with more than 100 followers in northern California. A temple was built in Redwood Valley, a small community in Mendocino County near Ukiah, California. Within a few years, Reverend Jones opened churches in San Francisco and Los Angeles. Subsequently, the Temple's headquarters was shifted to San Francisco. Reverend Jones became active in politics and was publicly identified with many national, State, and local political figures. He also initiated action toward establishing an agricultural development community in Guyana in late 1973 and Temple member emigrations to Guyana began in early 1977.

Temple members included attorneys who assisted Reverend Jones and other Temple members on legal questions ranging from obtaining guardianships of children to operating nonprofit corporations that were primarily engaged in acquiring property for the Temple.

Also in late 1976 Reverend Jones was appointed Chairman of the San Francisco Housing Authority Commission by the mayor of San Francisco. Shortly after this appointment, a national magazine article critical of life in the Peoples Temple was published. By this time, Temple members had begun to emigrate to Guyana, and Reverend Jones had resigned from the Housing Authority while he was in Guyana.

On November 18, 1978, the tragedy at Jonestown, Guyana, occurred. Of the 913 people who died there, about one-third were under 19 years of age.

SCOPE OF REVIEW

We conducted our work at the U.S. Department of State in Washington, D.C., the California Department of Social Services, and 13 counties in California. Most of our work was in three northern California counties (Alameda, Mendocino, and San Francisco) and one southern California county (Los Angeles) because these were the primary counties where Peoples Temple activities were concentrated. Work was also performed in the bordering counties of Contra Costa, Napa, Orange, Riverside, Santa Clara, San Bernardino, San Diego, San Mateo, and Sonoma. About 74 percent of California's 25,000 foster care children reside in the 13 counties where we made our review.

From two U.S. Department of State lists of verified and unverified Peoples Temple members who died in Guyana and a listing compiled by a Peoples Temple attorney of all the persons who emigrated to Jonestown from the San Francisco area, we identified 337 children who were in Guyana at the time of the tragedy and who were born on or after January 1, 1960. We used this listing of children in making our review and analysis.

All of the names of the Peoples Temple members who emigrated to Guyana were checked against the State's Medi-Cal historical files. In addition, we subpoenaed and examined county welfare records of the children that were identified in the review of the Medi-Cal files. With the assistance of State and county officials, we identified the children that had a welfare history and reviewed the available case files for these children.

FEDERAL FUNDING OF FOSTER CARE PROGRAMS

Title IV-A of the Social Security Act (42 U.S.C. 608) makes Federal matching funds available to the States under the Aid to Families with Dependent Children (AFDC) program for foster home care of dependent children. In fiscal year 1979 Federal funding for title IV-A foster care is estimated at $241 million.

The Federal Government also contributes to the support of foster children through title IV-B (42 U.S.C. 620) and title XX (42 U.S.C. 1397) of the Social Security Act. These programs provide Federal matching funds to support child welfare services and social services to adults and children. In fiscal year 1979, Federal funding for the title IV-B child welfare services program is estimated at $56.5 million. Federal funding for the fiscal year 1979 title XX social services program is estimated at $2.9 billion. The total State and Federal title IV-A, IV-B, and XX funds allocated for foster care was almost $1.2 billion for fiscal year 1977, the latest year for which this information is available.

CALIFORNIA'S FOSTER CARE PROGRAM

The State of California Department of Social Services has overall responsibility for administering the State's foster care program for children. However, the individual counties operate their own foster care systems. The State provides the counties with administrative guidance, program oversight, and fiscal support in the operation of the counties' foster child placement programs.

In fiscal year 1978, California spent $46.3 million of Federal funds authorized under title IV-A and XX and $121.5 million of State and county funds for its foster care program. The State did not spend any of its title IV-B funds for foster care.

PLACING CHILDREN INTO FOSTER CARE

Children enter foster care in one of two ways--by a court directing placement because of the child's behavior and/or home situation or by the parents voluntarily allowing a placing agency, such as a welfare department, to place the child outside the home. Federal law makes a judicial determination a condition for AFDC-foster care eligibility. As a result, children whose placements are not court ordered are not eligible for AFDC.

To be eligible for Federal funding, each foster care child must have a case plan and a redetermination of Federal eligibility must be accomplished every 6 months. There are no Federal regulations requiring visits by welfare caseworkers to foster children.

CIRCUMSTANCES CONCERNING THE EMIGRATION OF FOSTER CHILDREN TO JONESTOWN, GUYANA

Of the more than 900 Temple members who emigrated to or were born in Guyana, we identified 337 children who were under 19 years of age (born on or after January 1, 1960) at the time of the tragedy in November 1978.

Of the 337 children identified, we were able to determine that 248 of the children had a prior welfare history--223 of the children were previously recipients of cash grant and non-cash aid programs, and 25 of the children were previously recipients of only non-cash aid programs such as food stamps and Medi-Cal. Of the 223 children in cash grant programs, 204 children were previously in the Aid to Families with Dependent Children program, 3 children were previously in the federally supported foster care program, and 16 children were previously in the foster care program funded solely by the State and counties.

DEMOGRAPHICS AND OTHER INFORMATION ON 19 FOSTER CARE CHILDREN

At this point I would like to discuss some of the demographic data and other information that we obtained in our review concerning the status of the 19 children who were in the foster care program.

Of the 19 foster care children who emigrated to Guyana, 16 children have been reported as perished in Guyana, 2 children have been reported as surviving, and the status of one child has not been resolved. Of the 19 foster care children who emigrated to Guyana, 12 had been placed with Peoples Temple members.

We have attached to our prepared statement a case profile for each of the 19 children who were in a foster care status at some time prior to their emigration to Guyana.

Sex, ethnic background, and age of children

Twelve of the children were females and seven were males. Sixteen of the children were black and three were caucasian. Two of the children were from 5 to 7 years old, four were from 8 to 10 years old, six were from 11 to 13 years old, six were from 14 to 16 years old, and one was over 18 years old.

Children's family status and persons accompanying children to Guyana

At the time of departure for Guyana, four of the children had been reunited with and were accompanied by one or both of their parents or a relative, six of the children had been living with a relative but were not accompanied by a relative, two were accompanied by their adoptive mother, two were accompanied by their legal guardians, two children had a legal guardian but did not depart with the guardian, and one child had been adopted but did not depart with the adoptive parents. We were unable to determine the family status or departure circumstances for two of the children.

Also, information was not available which showed who accompanied the nine children who were under the custody of but were not accompanied by their relatives, guardians, or adoptive parents. However, certain information was available that related to departure circumstances of these children. For example, a mother who had custody of her five children (all former foster care children) signed passport applications for sending four of them to Guyana at different times--two children left for Guyana in July of 1977, one child left in August 1977, and one child left in October 1977. The mother departed for Guyana with the fifth child in August of 1978.

We reviewed the passport applications for 18 of the 19 foster care children to obtain information on their reported reason for leaving the United States. The passport applications showed that 12 of the foster children were leaving for a "vacation" for a period of from 20 days to 6 months. Of the remaining six children, three were reported leaving for Peoples Temple agricultural mission work, one for Peoples Temple human services work, and two did not indicate a reason for leaving.

Length of time out of foster care at time of departure for Guyana

Only 1 of the 19 children was still in foster care at the time of departure to Guyana. Three of the children had terminated from foster care less than 4 months prior to departure, four from 4 months to 1 year, three from 1 to 1-1/2 years, one from 1-1/2 to 2 years, six from 4 to 5 years, and one over 6 years.

With regard to the one child who was continued in paid foster care, payments of $150 a month from May through November 1977, or a total of $1,050 were made to her foster parent, who remained in California after she went to Guyana. In December 1977, the county terminated foster care payments because the county had lost contact with the foster parent. In March 1979, the State determined that the payments were not allowable since the child was not eligible for foster care while out of the country and referred the case to the county welfare department for action to recover the unallowable payments.

For the three children for whom foster care was terminated within 4 months before their departure to Guyana, we obtained the following information.

1. A child's foster parent/guardian took the child to Guyana in July 1977. County foster care payment checks were issued in July and August 1977 and sent to the foster parent's former address in California, but were returned to the county by the Postal Service. The county terminated the child from foster

care because the foster parent/guardian failed to maintain contact with the county. The foster parent/guardian obtained court approval to take the child to Guyana.

2. A mother under a court order issued in July 1977 was permitted to emigrate to the Peoples Temple agricultural project in Guyana for 3 years. The Federal judge also permitted the mother to take her 5 year old child with her to Guyana. The child had been living with its foster care parents from October 1976 to July 1977, when foster care payments were terminated.
3. A child who was a ward of the court had been living with his foster parents from June 1974 to March 1976, when foster care payments were terminated. In March 1976, the court removed him from foster care and placed him in a juvenile detention facility. A non-related guardian and Peoples Temple member obtained court approval in April 1976 to take the child to Guyana. In June 1976, the child departed to Guyana unaccompanied by his guardian.

Two of the four children for whom foster care was terminated from 4 months to 1 year prior to going to Guyana were in foster care from July 1964 to June 1977. In July 1977, the two children were placed in pre-adoption with their foster mother. State subsidized adoption payments were made to the adoptive parents after foster care stopped. The two children were taken to Guyana by their adoptive mother in April 1978, the same month that their adoption was finalized.

For most of the remaining children, foster care payments were terminated because the children had returned to a relative, usually their mother.

GUARDIANSHIPS

Of the 337 children who emigrated to Guyana, 31 were or had been under guardianship of Peoples Temple members. Included in the 31 children were 9 children who had been in foster care.

In the early 1970s, children were being placed in unlicensed homes of Peoples Temple members in Mendocino County by placement agencies in other California counties. Mendocino County officials raised objections to the counties because this practice was contrary to State and county regulations which required that foster children be placed in licensed facilities.

During the same period, Peoples Temple attorneys and members began filing petitions for guardianship of children for Peoples Temple members. Under the guardianship arrangement, children were placed in Temple members' homes which were exempted from the licensing requirement and the children were not under the jurisdiction of the Department of Social Services.

In our review, we found that nine of the foster children were or had been under guardianship arrangements with members of the Peoples Temple. The guardians of seven of the nine children received foster care payments for the care of these children. However, only one of the guardians that received foster care payments had a foster home license. State regulations require an evaluation of unlicensed guardian homes to assess whether the social and psychological needs of the child are being met. In our ongoing review we plan to obtain additional information on these evaluations.

Court approval to remove children under guardianship from the State

By letter dated April 12, 1979, we asked a judge of the Probate Department of the California Superior Court to provide us with legal references and to clarify the issue of whether a guardian may change the minor's domicile outside the State without prior court approval. Although we had not received a written response from the judge, he advised us informally on May 11, 1979, that he is not aware of any California statutory requirement that a guardian must obtain court approval for a change of the minor's domicile outside the State, except in situations where a child is a ward of the court placed through the court's probation department. We have undertaken legal research in an attempt to determine the legal requirements regarding this issue.

California Assembly Bill (AB) 261 introduced by Assemblyman Alister McAlister on January 11, 1979, contains a provision that would require that all changes of a minor's domicile outside the State of California be approved by the court. The bill was before the Committee on Judiciary as of May 15, 1979.

We noted that in two of the nine foster care/guardianship cases, the guardians had obtained court approval to take their wards to Guyana.

FOSTER CARE PAYMENTS

Payments to the foster care parents of the 19 children who spent some time in foster care totaled about $75,000 for the total time period that the children were in foster care, including $50,000 paid to foster parents associated with the Peoples Temple. About $5,800 of the $75,000 was provided from title IV-A funds for the three federally funded foster care children. Included in the $5,800 is $750 of Federal funds for a child who was placed in foster care with a non-Temple member who was determined by the State in 1979 to be ineligible for Federal funding. Additionally, an indeterminable amount of Federal title XX funds may have been used to provide social services to some of the 19 children while they were in foster care.

Included in the total of $75,000 is State foster care payments of $1,050 that were not allowable because they were made for a child who was out of the country, as I previously discussed.

INVESTIGATIVE EFFORTS OF OTHER FEDERAL, STATE, AND LOCAL AGENCIES

We coordinated our review with the offices of the HEW Inspector General, the State of California Department of Social Services and Welfare Fraud Investigation and Prevention Bureau, and the welfare agencies in the counties.

The initial Inspector General's review objective was to followup on any improper Federal foster care payments made to Peoples Temple members, relying primarily on the work performed in GAO's analysis of individual case files. Their subsequent review is to be directed toward the Federal, State, and county monitoring of the foster care program in California. As part of its monitoring review, the Inspector General plans to determine which actions have been taken on the recommendations contained in our report entitled "Children in Foster

Care Institutions--Steps Government Can Take to Improve Their Care" (HRD-77-40, dated February 22, 1977). Also, Social Security, Supplemental Security Income (SSI), and AFDC payments made to Peoples Temple members are being investigated by the Social Security Administration.

The State's investigative efforts primarily have been directed toward determining whether improper AFDC and foster care payments have been made. As of March 1979, the State had identified 17 AFDC cases where payments were made to families after one or more of the family members had moved to Guyana. The State estimates that the overpayments in these 17 cases will amount to about $20,000. The State is working with the U.S. Department of State to establish firm departure dates to Guyana of the Peoples Temple members who were on AFDC in order to determine whether additional overpayments have been made. Under the AFDC matching arrangements, about half of any overpayments would have been made with Federal funds. At this time, the State has not found any instances where foster care payment checks were mailed directly to Guyana.

Some of the county welfare departments performed independent reviews of their computer files. These reviews did not identify any additional children with foster care histories beyond the 19 foster children previously discussed. These county agencies are still in the process of completing their investigations of possible AFDC overpayments.

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Mr. Chairman, that concludes our statement. We will be happy to answer any questions that you may have.

CASE A

Age as of November 1978: 18 years

Sex: Female

Ethnic background: Black

Foster care period (s): April to May 1977
February to March 1978

Eligible for Federal or State foster care: State

Estimated total foster care payments
while in foster care: $819

Length of time out of foster care
at time of departure for Guyana: 4 months to 1 year

Child's family status at time of
departure for Guyana: She was of legal age prior to going to Guyana.

Person(s) accompanying child to Guyana: Unknown

Were the child's foster parents or
guardians Temple members?: No

Was the child under guardianship?: No

This child departed for Guyana in July 1978. She was reportedly wounded at the airport when Congressman Ryan and others were killed. She is reported to be alive in California.

CASE B

Age as of November 1978: 13 years

Sex: Male

Ethnic background: Caucasian

Foster care period (s): October 1975 to February 1976

Eligible for Federal or State foster care: State

Estimated total foster care payments
while in foster care: $745

Length of time out of foster care
at time of departure for Guyana: 1 to 1-1/2 years

Child's family status at time of
departure for Guyana: Returned to grandfather in March 1976

Person(s) accompanying child to Guyana: Unknown

Were the child's foster parents or
guardians Temple members?: Yes

Was the child under guardianship?: Yes, September 1975

This child left foster care in March 1976 and returned to a relative (grandfather). The child left for Guyana in June 1977 without the grandfather. Information is not available at this time on who accompanied the child to Guyana. This child is on the Department of State's list of unverified deceased.

CASE C

Age as of November 1978: 6 years

Sex: Male

Ethnic background: Black

Foster care period (s): October 1976 to July 1977

Eligible for Federal or State foster care: State
(Although ineligible because of voluntary placements, this child was claimed by the county for Federal foster care.)

Estimated total foster care payments while in foster care: $1,521

Length of time out of foster care at time of departure for Guyana: Less than 4 months

Child's family status at time of departure for Guyana: Returned to mother in July 1977

Person(s) accompanying child to Guyana: Mother

Were the child's foster parents or guardians Temple members?: No

Was the child under guardianship?: No

This child left foster care in July 1977 and returned to his mother. The mother had been placed on 3 years probation by a Federal District Court with the Peoples Temple agricultural project in Guyana. The authorization to travel was signed by a Federal District Court Judge. The mother and child departed for Guyana in July 1977. This child is on the Department of State's list of unverified deceased.

CASE D

Age as of November 1978: 12 years

Sex: Female

Ethnic background: Caucasian

Foster care period(s): November 1973 to August 1975

Eligible for Federal or State foster care: State

Estimated total foster care payments
while in foster care: $1,349

Length of time out of foster care
at time of departure for Guyana: 1-1/2 to 2 years

Child's family status at time of
departure for Guyana: In custody of guardian/aunt and guardian/friend

Person(s) accompanying child to Guyana: Unknown

Were the child's foster parents or
guardians Temple members?: Yes

Was the child under guardianship?: Yes, September 1973

This child had two guardians--one was an aunt and the other was not related. Foster care payments were made for the child while she was living with her non-related guardian. On separate days in July and August 1977, she and her two guardians went to Guyana. She is on the Department of State's list of unverified deceased.

CASE E

Age as of November 1978: 16 years

Sex: Female

Ethnic background: Black

Foster care period(s): July 1964 to June 1977

Eligible for Federal or State foster care: State

Estimated total foster care payments
while in foster care: $8,497

Length of time out of foster care
at time of departure for Guyana: 4 months to 1 year

Child's family status at time of
departure for Guyana: Adopted

Person(s) accompanying child to Guyana: Adoptive mother

Were the child's foster parents or
guardians Temple members?: Yes

Was the child under guardianship?: No, adopted in April 1978

In addition to foster care payments, an undisclosed amount of State subsidized adoption funds were paid for this child to the adoptive family. The child and her adoptive mother went to Guyana in April 1978. The child is on the Department of State's list of unverified deceased.
(Related case: See case D for data on another child simultaneously adopted by the same adoptive mother.)

CASE F

Age as of November 1978: 12 years

Sex: Male

Ethnic background: Black

Foster care period(s): October 1969 to March 1973

Eligible for Federal or State foster care: Both

Estimated total foster care payments while in foster care: $3,989

Length of time out of foster care at time of departure for Guyana: 4 to 5 years

Child's family status at time of departure for Guyana: Adopted

Person(s) accompanying child to Guyana: Unknown

Were the child's foster parents or guardians Temple members?: Yes

Was the child under guardianship?: No

In July 1977, this child went to Guyana without his adoptive parents. Information is not available at this time on who accompanied this child to Guyana. He is on the Department of State's list of verified deceased.

CASE G

Age as of November 1978: 14 years

Sex: Female

Ethnic background: Black

Foster care period(s): October 1975 to March 1976

Eligible for Federal or State foster care: State

Estimated total foster care payments while in foster care: $696

Length of time out of foster care at time of departure for Guyana: 1 to 1-1/2 years

Child's family status at time of departure for Guyana: Returned to mother in March 1976

Person(s) accompanying child to Guyana: Mother

Were the child's foster parents or guardians Temple members?: Yes

Was the child under guardianship?: Yes, July 1975

This child was returned from foster care to her mother in March 1976. She and her mother went to Guyana in August 1977. This child is on the Department of State's list of verified deceased. (Related case: See case H for data on this child's sister.)

CASE H

Age as of November 1978: 15 years

Sex: Female

Ethnic background: Black

Foster care period(s): October 1975 to March 1976

Eligible for Federal or State foster care: State

Estimated total foster care payments
while in foster care: $1,046

Length of time out of foster care
at time of departure for Guyana: 1 to 1-1/2 years

Child's family status at time of
departure for Guyana: Returned to mother in March 1976

Person(s) accompanying child to Guyana: Mother

Were the child's foster parents or
guardians Temple members?: Yes

Was the child under guardianship?: Yes, July 1975

This child was returned from foster care to her mother in March 1976. She and her mother went to Guyana in August 1977. This child is on the Department of State's list of verified deceased. (Related case: See case G for data on this child's sister.)

CASE I

Age as of November 1978: 8 years

Sex: Female

Ethnic background: Black

Foster care period(s): November 1971 to March 1973

Eligible for Federal or State foster care: State

Estimated total foster care payments while in foster care: $2,834

Length of time out of foster care at time of departure for Guyana: 4 to 5 years

Child's family status at time of departure for Guyana: Returned to mother

Person(s) accompanying child to Guyana: Unknown, mother followed 13 months later

Were the child's foster parents or guardians Temple members?: No

Was the child under guardianship?: No

This child returned from foster care to her mother in March 1973. In 1976 the family moved from Los Angeles to San Francisco. The child went to Guyana in July 1977. Information is not available at this time on who accompanied this child to Guyana. Her mother signed the passport application and subsequently went to Guyana in August 1978. This child is on the Department of State's list of unverified deceased. (Related cases: See cases J and K for data on this child's half-sisters, and cases L and R for child's half-brothers.)

CASE J

Age as of November 1978: 9 years

Sex: Female

Ethnic background: Black

Foster care period(s): November 1971 to March 1973

Eligible for Federal or State foster care: State

Estimated total foster care payments while in foster care: $2,084

Length of time out of foster care at time of departure for Guyana: 4 to 5 years

Child's family status at time of departure for Guyana: Returned to mother

Person(s) accompanying child to Guyana: Unknown, mother followed 13 months later

Were the child's foster parents or guardians Temple members?: No

Was the child under guardianship?: No

This child was returned from foster care to the home of her mother in March 1973. In 1976 the family moved from Los Angeles to San Francisco. This child departed for Guyana in August 1977. Information is not available at this time on who accompanied this child to Guyana. Her mother signed the passport application and subsequently went to Guyana in August 1978. This child is on the Department of State's list of unverified deceased.
(Related cases: See case I for data on this child's half-sister, case K for child's sister, and cases L and R for child's half-brothers.)

382

CASE K

Age as of November 1978: 11 years

Sex: Female

Ethnic background: Black

Foster care period(s): May 1970 to September 1973

Eligible for Federal or State foster care: State

Estimated total foster care payments
while in foster care: $6,715

Length of time out of foster care
at time of departure for Guyana: 4 to 5 years

Child's family status at time of
departure for Guyana: Returned to mother

Person(s) accompanying child to Guyana: Mother

Were the child's foster parents or
guardians Temple members?: No

Was the child under guardianship?: No

This child was returned from foster care to the home of her mother in September 1973. The family moved from Los Angeles to San Francisco in 1976. This Child departed for Guyana in August 1978 with her mother. This child is not on either of the Department of State's lists of deceased, but is assumed to have perished in Guyana. On May 9, 1979, a U.S. Department of State official confirmed with us that this child should be on the list of unverified deceased.
(Related cases: See case I for data on child's half-sister, case J for sister and cases L and R for half-brothers.)

CASE L

Age as of November 1978: 16 years

Sex: Male

Ethnic background: Black

Foster care period(s): May 1970 to May 1973

Eligible for Federal or State foster care: State

Estimated total foster care payments while in foster care: $5,129

Length of time out of foster care at time of departure for Guyana: 4 to 5 years

Child's family status at time of departure for Guyana: Returned to mother

Person(s) accompanying child to Guyana: Unknown, mother followed 12 months later

Were the child's foster parents or guardians Temple members?: No

Was the child under guardianship?: No

This child was returned from foster care to the home of his mother in May 1973. The family moved from Los Angeles to San Francisco in 1976. He departed for Guyana in July 1977. Information is not available at this time on who accompanied this child to Guyana. His mother signed the passport application and subsequently went to Guyana in August 1978. This child is on the Department of State's list of unverified deceased.
(Related cases: See cases I, J, and K for data on child's half-sisters and R for half-brother.)

CASE M

Age as of November 1978: 8 years

Sex: Female

Ethnic background: Black

Foster care period(s): November 1970 to March 1971

Eligible for Federal or State foster care: State

Estimated total foster care payments while in foster care: $424

Length of time out of foster care at time of departure for Guyana: Over 6 years

Child's family status at time of departure for Guyana: Under guardian

Person(s) accompanying child to Guyana: Unknown

Were the child's foster parents or guardians Temple members?: Yes

Was the child under guardianship?: Yes, September 1978

This child was returned from foster care to her mother in March 1971. Upon return to her mother, the child was sent to live with Peoples Temple members in Mendocino County. The child remained with these people until her departure for Guyana in September 1978; however, no foster care payments were made. She was on the Peoples Temple attorney's list of emigrants to Guyana. Information is not available at this time on who accompanied her to Guyana. She is not on either of the Department of State's lists of deceased.

CASE N

Age as of November 1978: 5 years

Sex: Female

Ethnic background: Black

Foster care period(s): September 1974 to June 1977
(Foster care payment checks were sent by the county to the foster parent's former address in California in July and August 1977 but were returned to the county by the Postal Service. The county then terminated this child from foster care because the foster parent failed to maintain contact with the county.)

Eligible for Federal or State foster care: State

Estimated total foster care payments
while in foster care: $4,400

Length of time out of foster care
at time of departure for Guyana: Less than 4 months

Child's family status at time of
departure for Guyana: Under guardianship

Person(s) accompanying child to Guyana: Guardian

Were the child's foster parents or
guardians Temple members?: Yes

Was the child under guardianship?: Yes, June 1974

This child was placed when about a year old with a foster parent/guardian who was a Temple member. In July 1977, she and her guardian went to Guyana. The guardian had obtained court approval to take her to Guyana. She is on the Department of State's list of unverified deceased.

CASE O

Age as of November 1978: 14 years

Sex: Male

Ethnic background: Black

Foster care period(s): July 1964 to June 1977

Eligible for Federal or State foster care: State

Estimated total foster care payments while in foster care: $8,497

Length of time out of foster care at time of departure for Guyana: 4 months to 1 year

Child's family status at time of departure for Guyana: Adopted

Person(s) accompanying child to Guyana: Adoptive mother

Were the child's foster parents or guardians Temple members?: Yes

Was the child under guardianship?: No, adopted in April 1978

In addition to foster care payments, an undisclosed amount of State subsidized adoption funds were paid for this child to the adoptive family. The child and his adoptive mother went to Guyana in April 1978. The child is on the Department of State's list of unverified deceased. (Related case: See case E for data on another child simultaneously adopted by the same adoptive mother.)

CASE P

Age as of November 1978: 15 years

Sex: Male

Ethnic background: Caucasian

Foster care period(s): June 1974 to March 1976

Eligible for Federal or State foster care: Both

Estimated total foster care payments while in foster care: $6,175

Length of time out of foster care at time of departure for Guyana: Less than 4 months

Child's family status at time of departure for Guyana: Under guardianship

Person(s) accompanying child to Guyana: Unknown

Were the child's foster parents or guardians Temple members?: Yes

Was the child under guardianship?: Yes, April 1976

This child left foster care in March 1976 to be placed with a legal guardian who did not receive foster care funds. The child went to Guyana in June 1976 without his guardian. His legal guardian later went to Guyana but came back to the United States leaving the child there. Information is not available at this time on who accompanied this child to Guyana. The child is on the Department of State's list of verified deceased.

guardians (who received no foster care payment) took her to Guyana, but foster care payments continued to be made to her foster parent (the daughter of her first guardian). Payments were terminated in November 1977 because the county lost contact with the foster parent. Although this child is on the Department of State's list of unverified deceased, State officials report that she survived Guyana and currently resides in northern California.

CASE Q

Age as of November 1978: 9 years

Sex: Female

Ethnic background: Black

Foster care period(s): June 1971 to December 1974, February 1976 to November 1977--this child was in a foster care home in April 1979

Eligible for Federal or State foster care: State

Estimated total foster care payments while in foster care: $7,315 (Does not include foster care payments after her return from Guyana)

Length of time out of foster care at time of departure for Guyana: Foster care continued after she went to Guyana

Child's family status at time of departure for Guyana: Under foster care/guardianship

Person(s) accompanying child to Guyana: With legal guardian

Were the child's foster parents or guardians Temple members?: Yes

Was the child under guardianship?: Yes, January 1971 and June 1974

This child has been in some type of foster care most of her life. Her first foster parent/guardian was non-related and died in 1974. The child lived with the daughter of the deceased guardian until she was placed with two non-related guardians in June 1974. After placement with her new guardians, she continued to live with the daughter of her first guardian, who received foster care payments as a foster parent. In April 1977, her

CASE R

Age as of November 1978: 13 years

Sex: Male

Ethnic background: Black

Foster care period(s): May 1970 to September 1973

Eligible for Federal or State foster care: State

Estimated total foster care payments while in foster care: $5,778

Length of time out of foster care at time of departure for Guyana: 4 to 5 years

Child's family status at time of departure for Guyana: Returned to mother

Person(s) accompanying child to Guyana: Unknown, mother followed 10 months later

Were the child's foster parents or guardians Temple members?: No

Was the child under guardianship?: No

This child was returned to his mother from foster care in September 1973. The family relocated from Los Angeles to San Francisco in 1976. In October 1977, the child went to Guyana. Information is not available at this time on who accompanied this child to Guyana. His mother signed the passport application, and subsequently went to Guyana in August 1978. This child is on the Department of State's list of unverified deceased. (Related cases: See cases I, J, and K for data on child's half-sisters and case L for half-brother.)

CASE S

Age as of November 1978: 12 years

Sex: Female

Ethnic background: Black

Foster care period(s): May 1973 to March 1977

Eligible for Federal or State foster care: State

Estimated total foster care payments
while in foster care: $6,290

Length of time out of foster care
at time of departure for Guyana: 4 months to 1 year

Child's family status at time of
departure for Guyana: With guardian

Person(s) accompanying child to Guyana: Unknown

Were the child's foster parents or
guardians Temple members?: Yes

Was the child under guardianship?: Yes, March 1973; December 1975

This child was in foster care during two time periods with two different non-related guardians who were Peoples Temple members. She went to Guyana in August 1977. Information is not available at this time on who accompanied this child to Guyana. She is on the Department of State's list of verified deceased.

Senator **Cranston**. In your testimony, you stated that you used more than just the U.S. Department of State lists of the deceased in Jonestown to identify the foster care children. Why was it necessary to get at additional material in order to make that identification as to the foster care children.

Mr. **Curtis**. Mr. Chairman, the lists that were provided to us by the Department of State did not contain all of the names of those who died in the tragedy at Jonestown. Their list identified about 850 of the 913 people.

Therefore, we went to and obtained from a Peoples Temple attorney a list of the people who had emigrated from the San Francisco area; and were, therefore, able to do a much better job than if we had had to rely only on the Department of State lists.

Senator **Cranston**. Why were the State Department lists inadequate?

Mr. **Curtis**. The Department of State lists simply did not have firm identification of all the people who had emigrated to Guyana.

Mr. **Bowden**. If I could add a comment, the State Department used a criteria of requiring some tangible evidence of presence in Jonestown, such as a passport. They did not have such evidence for all the people.

Senator **Cranston**. You indicated that information was not available showing who accompanied 9 of the 19 foster care children who emigrated to Guyana. Have you obtained any additional information which would shed some light on the circumstances involved in removing those children from this country and taking them down there?

Mr. **Quattrociocchi**. Yes; we have obtained some information on the methods that the Peoples Temple used to bring the children to Guyana.

For example, we found that the Temple used an assignment-of-custody document that granted custody for 18 of the 19 foster care children to members of the Peoples Temple.

The documents granted the custodians—usually three in number—unlimited authority over the control of the child, and were authorized by a parent or legal guardian of the child.

The total number of Temple members who were assigned custody were few in number.

For example, one person was assigned as a custodian for 17 of the 18 foster care children.

The three assigned custodians usually reside in different locations—one in San Francisco, one in Jonestown, Guyana, and one in Georgetown, Guyana.

The assignment documents also authorized unlimited future assignments of custody of the children.

We are still pursuing this issue and hope to get a more complete story before our review is completed.

Senator **Cranston**. The Peoples Temple was, apparently, extensively engaged in obtaining guardianships of children by Peoples Temple members. In your review, have you bene able to obtain any insight as to why they were seeking the guardianships and following that path?

Mr. **Neuman**. Yes, Mr. Chairman. We were able to obtain documentation which showed that in May 1971, Mendocino County officials were very critical of the poor palcement practices of Alameda County placing children in unlicensed homes; and they urged Alameda County officials to discontinue such practices as soon as possible.

Some of this documentation also pointed out that there had been several cases under review by Mendocino County which concerned the protection of the children from what was termed "unsuitable and unwarranted guardianship actions by the Peoples Temple."

And just a few months ago, in fact, in February, we also were informed by the Director of Mendocino County Department of Social Services that he was of the opinion that the guardianship arrangements by the Peoples Temple were a means of circumventing the necessity of obtaining foster home licenses for members.

Then, as a final note, just yesterday we were informed by the deputy attorney general in San Francisco that he was also undertaking a review of the former foster care children who went to Guyana, and that, as part of his review, emphasis would be placed on the guardianship arrangements.

Senator CRANSTON. Thank you for that explanation.

Could you further elaborate on the additional work you plan to do in the area of guardianship, the objectives of that phase of your review, and what will be discussed in the report that you plan to send to the subcommittee later on this year?

Mr. BOWDEN. Yes, Mr. Chairman. We have four major objectives.

Our first objective is to determine the legal requirements and restrictions placed upon guardians by the State statutes. Our second objective is to determine if the State requirement for welfare agency reviews of potential nonrelated adult guardians are being done, and if the reviews are adequate.

Our third objective is to determine the extent that foster care payments are being made to guardians in unlicensed homes, and the extent that Federal funds are used to make these payments.

Our last objective is to determine the adequacy of the welfare agency evaluations of the unlicensed homes.

We expect to discuss in our report to you later this year the frequency of these occurrences, and plan to make recommendations to assure that any deficiencies noted will be corrected.

Senator CRANSTON. In your testimony, you stated that in two instances checks were mailed to foster parents after the foster child had departed for Guyana; in one case, the checks were returned without being cashed, and, in the other case, payment continued for 7 months.

Do you have any information as to how those mailings of payments occurred and why the counties were not aware that the foster child in each case had emigrated to Guyana?

Mr. BOWDEN. Yes, sir. We have some information. It's not quite complete, because, as we stated, we are continuing on the guardianship aspect.

Both of these foster care children were also under guardianship. And, as we noted, State regulations do not require departments of social service caseworkers, to visit foster parents of foster children, where guardianships are involved.

Consequently, in these two cases, San Francisco County was not aware of the fact that these children had left the country. The county records showed that the county had closed these cases because of a loss of contact with the foster care family.

In our future review work, we will obtain more information as to how this occurred and determined what can be done to preclude its recurrence.

Senator Cranston. Could you explain some of the difficulties that you encountered in trying to identify from State and county records the foster children who perished in Guyana and comment on the adequacy of the State and counties' information system on foster children?

Mr. Sorensen. Yes; I can give you a brief overview of several items that presented difficulties in trying to identify the children. The data supplied by the U.S. Department of State was incomplete.

The lack of social security numbers, birth dates, and middle names produced erroneous matches in the computer search. In several instances, we had to reslove the identity of a person, because the State Department had documented the death of a person, and the welfare system record showed the person was alive. In these cases, it turned out that we were talking about two different people.

The counties do not maintain computerized information systems for foster home licensees. So any check for Peoples Temple members among holders of foster home licenses had to be a manual process.

For example, Los Angeles County has literally thousands of foster-care homes in their record system—homes they have closed out—files maintained for 5 years—and current homes.

The manual search through their foster home licensing histories took 3 to 4 weeks.

The end result of that search was that they did not find any active homes listed for people who were on any of the various Temple membership lists used in the search. Neither the State nor the counties maintain a foster care tracking system. The individual names had to be checked against the general welfare history files.

The case files themselves were not always available for review. In some cases, the files had been closed out prior to 3 years of the date we were looking for the file; and California regulations allow destruction of records that are over 3 years old.

In other cases, the files could not be located. They had been either lost in storage or they were in a suspense status somewhere in a district office and the files themselves could not be found.

The available case files that were reviewed were not always complete. That is, the financial information might have been available; but the social services' records, which is a separate file, was generally not available.

Also, the case files did not always contain essential information; that is, explanatory narrations, social security numbers, eligibility documents, and needs assessments.

As a consequence, it took a significant investment in time for us to identify, acquire, verify, and develop the circumstances surrounding each of these foster children.

Senator CRANSTON. Thank you very much.

The subcommittee has obtained widely varying statistics on the number of foster children in the Nation. In your study, were you able to obtain firm information on the number of foster children in the country and the number in California?

Mr. CURTIS. We were not able to do that.

Our most recent estimate, from an official of HEW, is that countrywide it could be somewhere in the neighborhood of 500,000 children.

As of September 1978, when we obtained some statistics for California, the number in California was about 25,000.

Senator CRANSTON. 25,000?

Mr. CURTIS. Yes.

Senator CRANSTON. In your statement, you said the HEW Inspector General plans to look into action that's been taken on the recommendations contained in your 1977 report on children in foster care institutions.

Could you briefly summarize the major recommendations that GAO made in that report?

Mr. NEUMAN. Yes, Mr. Chairman. Some of the major recommendations concerned the need for improvement in the delivery and documentation of social services to institutionalized children; also the need for improvement in the licensing and inspection procedures.

There is a need to clarify Federal regulations regarding the ratesetting procedures in foster care institutions.

There is also a need for improvement in the mandatory visitations by social workers to institutionalized children; a need also to establish caseload guidelines, as well as case plans.

There is a need to clearly define the scope of services provided by AFDC foster care programs.

And one of the other major recommendations dealt with the need for closer HEW-monitoring of State and local foster care agencies.

I think that about covers it, Senator Cranston.

Senator CRANSTON. Thank you very much.

I thank each of you. You've been very helpful and very thorough and, obviously, very well prepared; and I look forward to your legislative recommendations.

Mr. CURTIS. Thank you.

Senator CRANSTON. Thank you for appearing here today.

Mr. BOWDEN. Thank you, Senator.

Mr. QUATTROCIOCCHI. Thank you.

Mr. NEUMAN. Thank you.

Mr. SORENSEN. Thank you.

Senator CRANSTON. Our final panel, now, consists of Keith Comrie, director of the L. A. County Department of Public Social Services; and Phil Manriquez, deputy director, of the Planning and Review Division, Department of Social Services, California Health and Welfare Agency.

Thank you very much for your being with us today.

STATEMENT OF KEITH COMRIE, DIRECTOR, LOS ANGELES COUNTY DEPARTMENT OF PUBLIC SOCIAL SERVICES; ACCOMPANIED BY SISTER MARY ELIZABETH, EXECUTIVE DIRECTOR, MARYVALE CHILDREN'S INSTITUTION; AND PHIL MANRIQUEZ, DEPUTY DIRECTOR, PLANNING AND REVIEW DIVISION, DEPARTMENT OF SOCIAL SERVICES, CALIFORNIA HEALTH AND WELFARE AGENCY.

Mr. COMRIE. Good morning, Senator Cranston.

Let me make the introductions, first. I am Keith Comrie, the Director of the local welfare department.

With me is Sister Mary Elizabeth, who is the executive director of an institution called Maryvale Children's Institution.

On my right is Phil Manriquez, who is a deputy director of the State department of social services.

By way of background, we administer the traditional welfare programs, which, of course, include AFDC, medicaid, food stamps, as well as child welfare services, which has as a component the foster care and institutional placement programs.

Approximately 9,000 abandoned and abused children are in out-of-home care at this time in Los Angeles County, with 80 percent in foster homes and 20 percent in institutions, and this is the group we're testifying to today.

Because of a deliberate, careful effort on our part to maintain children in their own homes whenever possible and safe, and with an extensive adoption program in California, and specifically in Los Angeles, rather than placing children in out-of-home care, that 9,000 current population reflects a 40-percent reduction over the 15,000 children that were in placement care just 7 years ago.

Now, as I mentioned earlier, Sister Mary Elizabeth, the executive director of the children's institution called Maryvale, is with me.

By way of background, Maryvale was established in 1856. Because of a call from the mayor the then-tiny frontier town of Los Angeles during a yellow fever epidemic, the Daughters of Charity of St. Vincent de Paul established the first city hospital and orphanage in Los Angeles.

By way of background, too, I believe the Los Angeles population at that time was 10,000 people.

Maryvale is that original orphanage and now specializes in troubled teenage girls; and the nationally-known St. Vincent's Hospital was the original city infirmary.

I am giving you this background because Maryvale is very typical of many child care institutions. That is, well before Government provided any such services, private charitable groups provided the adoption and out-of-home care services for our Nation's homeless children.

It was not until much later in our history that Government started formal programs in this area. Even today, it is common for such institutions to fund major portions of their costs from private charitable funds and receive only a portion of their costs from Government.

After I give you a short overview of the out-of-home care system in Los Angeles County, Sister Mary Elizabeth and I will be pleased to answer any further questions you may have.

I have Sister Mary Elizabeth here because they are the oldest institution we have. They are probably one of the oldest in the Nation; and they are typical of many of the child care institutions you will be reviewing.

Now, first in a system of controls to assure children get quality care in institutions, the State has a formal licensing system in California.

No facility can operate in California without a license.

Standards to be met are included in title XXII of the California Administrative Code, a copy of which I will leave with your staff for future review.

The standards cover such areas as supervision of children, arrest and health clearance records of persons caring for children; food, medical care, and facility physical standards.

Now, once a facility is licensed by the State, we have additional controls in Los Angeles to assure children receive appropriate care to their individual needs.

Before we place any children in a licensed facility, a special unit of my department performs an evaluation to make sure that it will meet the specific needs of the children we may place there.

We go beyond State licensing requirements to obtain answers to such questions as follows:

Does the actual program offered match the needs of the children we place there?

Do the operators and staff have a respect and caring attitude for children?

Are the operators, in fact, advocates for children?

What type of training and experience do they have?

And do they have a stable financial base?

To assist in this, we have a boarding homes and institutions handbook we provide to each institution and our staff that spells out these standards.

Once again, I will leave a copy with your staff for future review.

After the above community care licensing division approval of a facility for general county use, we then notify all 600 line children services workers of its programs for their evaluation and use with future children requiring placement.

We then have a separate unit, the child-care institution evaluation unit, make ongoing onsite visits to all approved facilities to be sure they continue to meet the needs of our children.

Currently, facilities are being visited routinely on an average of twice a year.

In addition, onsite special visits are also made based on requests from line children services workers that visit the facilities to see the children, and also from calls to—something unique to Los Angeles—our 24-hour child-abuse-reporting hotline.

In addition to the above, we are now testing something that's even more comprehensive and that's this large manual, which I think may be of use to your staff in development of the legislation that you're talking about this morning.

This is a codification of everything for our institutions and for our workers. It's entitled "Standards and Operational Procedures for Child-Care Institutions."

The manual was developed, under the direction of County Supervisor James Hayes, by a task force headed by our county superintendent of schools. We, of course, participated; but it was under the direction of our county superintendent of schools.

The intent of this manual is to provide a comprehensive guide for use by institutions, as well as monitoring staff use. It, of course, includes all of the traditional standards, such as basic child supervision requirements and physical plant needs.

In addition, it goes well beyond all of these standards and provides that each institution have program goals and objectives with measurements of success, provides guidelines for ongoing staff training, and provides detailed children's rights statements that are made available to all children in placement.

I would like to point out, because your staff may have not had it before, that we have continually worked with your office, and other congressional offices, on ideas on how to improve and balance and monitor the system; and one of the latest things we just put into effect recently is a children's rights statement that every child, that needs placement, receives in advance; and that gives him guidelines of what he should expect from the institution and my staff—whether it be proper diet; or, very specifically, corporal punishment is never permitted; and, as clearly spelled out, he's told to notify the facility administrator and his Children's Services worker immediately if it ever happens.

That I will leave with you also.

Let me pause here to point out, once again, that Los Angeles County has had a longstanding, positive, cooperative relationship with its institutional operators. They are a very professional and dedicated group of people.

The main reason the system works well is because of their efforts. All of the material we have discussed above has been developed jointly with their representatives.

This cooperative effort is mandatory if we are to have a quality child-care system.

As a result of these efforts, instances of institutional abuse in Los Angeles County are very rare. When they have occurred, they have been limited to individual institutional staff members who break established rules. Such problems have been immediately investigated and corrected.

Now, I believe I will leave it to you, as Chairman, as to whether you would like to ask questions of the Sister and myself, or if you would like Phil Manriquez to move ahead. Thank you.

Senator CRANSTON. Well, do either of you have anything to say at this point?

Sister MARY ELIZABETH. I haven't anything to offer at this time.

Senator CRANSTON. Very well.

[Note: The material referred to was retained in the files of the subcommittee. The prepared statement of Mr. Comrie follows:]

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC SOCIAL SERVICES

STATEMENT BY
KEITH COMRIE, DIRECTOR

FOR THE
SPECIAL HEARINGS ON FOSTER CARE

BY
U.S. SENATOR ALAN CRANSTON

MAY 31, 1979
LOS ANGELES, CALIFORNIA

Good morning, Senator Cranston. I am Keith Comrie, Director of the Los Angeles County Department of Public Social Services. We administer the traditional welfare programs such as Food Stamps, AFDC, and Medicaid, as well as child welfare services which has as components foster care and institutional placement. Approximately 9,000 abandoned and abused children are in out-of-home care at this time in Los Angeles, with 80% in foster homes and 20% in institutions. Because of a deliberate careful effort on our part to maintain children in their own homes whenever possible and safe, rather than placing them in out-of-home care, our 9,000 current population reflects a 40% reduction over the 15,000 in placement 7 years ago.

With me this morning is Sister Mary Elizabeth, Executive Director of the children's institution called Maryvale. By way of background, Maryvale was established in 1856. Because of a call from the Mayor of the then tiny frontier town of Los Angeles during a yellow fever epidemic, the Daughters of Charity of St. Vincent de Paul established the first city hospital and orphanage in Los Angeles. Maryvale is that original orphanage and now specializes in troubled teenage girls, and the nationally known St. Vincent's Hospital was the original city infirmary. I am giving you this background because Maryvale is typical of many child care institutions. That is, well before government provided any such services, private charitable groups provided the adoption and

AND OUT-OF-HOME CARE SERVICES FOR OUR NATION'S HOMELESS CHILDREN. IT WAS NOT UNTIL MUCH LATER IN OUR HISTORY THAT GOVERNMENT STARTED FORMAL PROGRAMS IN THIS AREA. EVEN TODAY, IT IS COMMON FOR SUCH INSTITUTIONS TO FUND MAJOR PORTIONS OF THEIR COSTS FROM PRIVATE CHARITABLE FUNDS AND RECEIVE ONLY A PORTION OF THEIR COSTS FROM GOVERNMENT. AFTER I GIVE YOU A SHORT OVERVIEW OF THE OUT-OF-HOME CARE SYSTEM IN LOS ANGELES COUNTY, SISTER MARY ELIZABETH AND I WILL BE PLEASED TO ANSWER ANY FURTHER QUESTIONS YOU MAY HAVE.

FIRST, IN A SYSTEM OF CONTROLS TO ASSURE CHILDREN GET QUALITY CARE IN INSTITUTIONS, THE STATE HAS A FORMAL LICENSING SYSTEM. NO FACILITY CAN OPERATE IN CALIFORNIA WITHOUT A LICENSE. STANDARDS TO BE MET ARE INCLUDED IN TITLE XXII OF THE CALIFORNIA ADMINISTRATIVE CODE, A COPY OF WHICH I WILL LEAVE WITH YOUR STAFF. THE STANDARDS COVER SUCH AREAS AS SUPERVISION OF CHILDREN, ARREST AND HEALTH CLEARANCES FOR PERSONS CARING FOR CHILDREN, FOOD, MEDICAL CARE, AND FACILITY PHYSICAL STANDARDS.

ONCE A FACILITY IS LICENSED BY THE STATE, WE HAVE ADDITIONAL CONTROLS IN LOS ANGELES TO ASSURE CHILDREN RECEIVE APPROPRIATE CARE TO THEIR INDIVIDUAL NEEDS.

-- BEFORE WE PLACE ANY CHILDREN IN A LICENSED FACILITY, A SPECIAL UNIT OF MY DEPARTMENT PERFORMS AN EVALUATION TO MAKE SURE IT WILL MEET THE SPECIFIC NEEDS OF THE CHILDREN WE MAY PLACE THERE. WE GO BEYOND STATE LICENSING REQUIREMENTS TO OBTAIN ANSWERS TO SUCH QUESTIONS AS:

--DOES THE PROGRAM OFFERED MATCH THE NEEDS OF THE CHILDREN WE MAY PLACE THERE?

--DO THE OPERATORS AND STAFF HAVE RESPECT AND CARING ATTITUDES FOR CHILDREN?

--ARE THE OPERATORS IN FACT ADVOCATES FOR CHILDREN?

--WHAT TYPE OF TRAINING AND EXPERIENCE DO THEY HAVE?

--DO THEY HAVE A STABLE FINANCIAL BASE?

TO ASSIST IN THIS, WE HAVE A BOARDING HOMES AND INSTITUTIONS HANDBOOK WE PROVIDE TO EACH INSTITUTION AND OUR STAFF THAT SPELLS OUT THESE STANDARDS. AGAIN, I WILL LEAVE A COPY WITH YOUR STAFF FOR FUTURE REVIEW.

-- AFTER THE ABOVE COMMUNITY CARE LICENSING DIVISION APPROVAL OF A FACILITY FOR GENERAL COUNTY USE, WE THEN NOTIFY ALL LINE CHILDREN SERVICES WORKERS OF ITS PROGRAMS FOR THEIR EVALUATION AND USE WITH FUTURE CHILDREN REQUIRING PLACEMENT. WE THEN HAVE A SEPARATE UNIT (THE CHILD CARE INSTITUTION EVALUATION UNIT) MAKE ONGOING ON-SITE VISITS TO ALL APPROVED FACILITIES TO BE SURE THEY CONTINUE TO MEET THE NEEDS OF OUR CHILDREN. CURRENTLY, FACILITIES ARE BEING VISITED ROUTINELY ON AN AVERAGE OF TWICE A YEAR. ON-SITE SPECIAL VISITS ARE ALSO MADE BASED ON REQUESTS FROM LINE CHILDREN SERVICES WORKERS AND CALLS TO OUR 24 HOUR CHILD ABUSE HOTLINE.

-- IN ADDITION TO THE ABOVE, WE ARE NOW TESTING AND INTEND ON UTILIZING ON A ROUTINE BASIS THIS LARGE BLUE NOTEBOOK ENTITLED "STANDARDS AND OPERATIONAL PROCEDURES FOR CHILD

CARE INSTITUTIONS." THIS MANUAL WAS DEVELOPED, UNDER THE DIRECTION OF COUNTY SUPERVISOR JAMES HAYES, BY A TASK FORCE HEADED BY OUR COUNTY SUPERINTENDENT OF SCHOOLS. THE INTENT OF THIS MANUAL IS TO PROVIDE A COMPREHENSIVE GUIDE FOR USE BY INSTITUTIONS AS WELL AS MONITORING STAFF. IT MAY BE USEFUL TO YOU AND YOUR STAFF IF YOU DECIDE TO MOVE ON NATIONAL STANDARDS. IT, OF COURSE, INCLUDES ALL OF THE TRADITIONAL STANDARDS FOR INSTITUTIONS SUCH AS BASIC CHILD SUPERVISION REQUIREMENTS AND PHYSICAL PLANT NEEDS. IN ADDITION, IT GOES WELL BEYOND ALL OF THESE STANDARDS AND PROVIDES THAT EACH INSTITUTION HAVE PROGRAM GOALS AND OBJECTIVES WITH MEASUREMENTS OF SUCCESS, PROVIDES GUIDELINES FOR ONGOING STAFF TRAINING, AND PROVIDES DETAILED CHILDREN'S RIGHTS STATEMENTS THAT ARE MADE AVAILABLE TO ALL CHILDREN IN PLACEMENT.

LET ME PAUSE HERE TO POINT OUT ONCE AGAIN THAT LOS ANGELES COUNTY HAS HAD A LONG-STANDING POSITIVE, COOPERATIVE RELATIONSHIP WITH ITS INSTITUTIONAL OPERATORS. THEY ARE A VERY PROFESSIONAL AND DEDICATED GROUP OF PEOPLE. THE MAIN REASON THE SYSTEM WORKS WELL IS BECAUSE OF THEIR EFFORTS. ALL OF THE MATERIAL WE HAVE DISCUSSED ABOVE HAS BEEN DEVELOPED JOINTLY WITH THEIR REPRESENTATIVES. THIS COOPERATIVE EFFORT IS MANDATORY IF WE ARE TO HAVE A QUALITY CHILD CARE SYSTEM. AS A RESULT OF THESE EFFORTS, INSTANCES OF INSTITUTIONAL ABUSE IN LOS ANGELES COUNTY ARE VERY RARE. WHEN THEY HAVE OCCURRED, THEY HAVE BEEN LIMITED TO INDIVIDUAL INSTITUTIONAL STAFF MEMBERS WHO BREAK ESTABLISHED RULES. SUCH PROBLEMS HAVE BEEN IMMEDIATELY INVESTIGATED AND CORRECTED. SISTER MARY ELIZABETH AND I WILL NOW BE PLEASED TO ANSWER ANY QUESTIONS YOU MIGHT HAVE.

Mr. MANRIQUEZ. Senator, my name is Phil Manriquez. I am representing Marion Woods; and what I would like to do initially is, on behalf of Director Woods, to thank you for inviting him to testify, and, then, to extend to you his apologies for not being able to be here today.

He did submit a statement to your committee. It is a rather lengthy one, and I would not want to take up your time in reading all of these pages. There are, however, a couple of points that I would like to highlight, if I could impose upon you.

Senator CRANSTON. All right. Then, we will take the whole statement in to the record.

Mr. MANRIQUEZ. Fine.

As director of the department of social services, Mr. Woods is responsible for, in general, supervising the administration of a number of programs that have bearing upon the matter that you are discussing today—the foster care component of the Aid to Families with Dependent Children program, children's protective services, the adoptions program in this State, and community care licensing.

I'd like to make just three points. One is in regards to some of the things that we are doing in the foster care area. One of the more exciting things that we have going on in the State right now is a demonstration project which has as its emphasis the concept of family reunification.

Now, this is a project that we hope to conclude in the next couple of years; and we're just in the process of completing our first evaluation of it.

We believe that by providing services to a family in crisis and by doing whatever is possible to keep the family functioning as a unit, we can avoid, to a great extent, the need for taking children out of their homes and placing them into arrangements, which include foster care placements.

Another effort that is going on is one which was alluded to by Mr. Comrie, and that is the emphasis in the adoptions area.

Another point I'd like to bring up is that in the proposed State budget for next year, we have proposed the expenditure of $5 million to establish a statewide 24-hour-response telephone line to report instances of child abuse or neglect.

Now, if that system becomes a reality, it will be available to immediately report instances of child abuse or neglect, whether they occur in foster care facilities or in private family homes.

By using this system, a caller will be able to call a social worker at any hour of the day or night; and the social worker will then be able to take appropriate steps to deal with the report; and, of course, depending on the circumstances, a call to report abuse or neglect could touch off an immediate investigation by a social worker or perhaps a law enforcement official.

The final point I would like to make is in the area of licensing, which was also mentioned by Mr. Comrie. This is probably one of the more critical elements of this whole body of services that is aimed to protect children from abuse and neglect.

Again, the statement gives you quite a bit of data about the number of facilities that are licensed by the county system and those that are licensed by the State system. I won't repeat those.

I would like to, however, just very briefly, touch upon the process that we follow in granting a license. The process that exists today is basically the same as that which has been in existence for several years, and there are procedures which both State and county licensing agencies carry out to insure that facilities meet and maintain certain licensing standards.

First, in the application process, we require prospective licensees to complete an application document, which provides key information on their home or the facility that they want licensed; and their plan of operation and the individuals who will be providing care.

We also require them to agree to a criminal records check and to submit a set of fingerprints to the licensing agency.

We then visit their home or their facility to insure that there exists basic adequacy for the type of care they intend to provide; and, if so, we instruct them to obtain any necessary clearances that they may need to operate in a particular locale. These would be things such as fire clearances, for example.

The fingerprints that I mentioned are, of course, sent to the Department of Justice in Sacramento, and, incidentally, once the record check has been submitted, the Department of Justice will send to the licensing agency any subsequent arrest reports.

This, of course, allows the licenses agency to monitor the possible criminal activities of all providers.

Now, once licensed, all facilities are subject to ongoing monitoring.

All residential facilities are visited at least once a year for reevaluation to insure they are operating in compliance with applicable laws and regulations.

You've already heard that, at least in Los Angeles County, to a great extent they do this twice a year.

We, additionally, respond to complaints from any source, even if they're anonymous, within 10 days of the complaint; and these reviews usually result in a visit to the facility.

I say "usually" because the nature of complaints varies widely, and our response varies accordingly.

Reports of physical abuse, though, are acted upon immediately and in all cases require a site visit; whereas, complaints about fiscal impropriety are not handled with the same urgency.

In this whole area of licensing, one of the more exciting things that we have going now is we've implemented a team of specially trained staff at the State level to deal with the more serious incidents that occur in a community facility.

In July of 1978, Director Woods approved the creation of a Client Protection Services Branch in the Community Care Licensing Division.

It's my understanding that this is rather unique. California is the only State that has an organization such as this.

The group is comprised of investigators, auditors, and enforcement consultants.

The consultants are assigned to specified contracting counties and State licensing officers to advise the licensing agency staff on a case-by-case basis regarding potential enforcement actions.

Their advice consists of telling the licensing staff what types of incidents require an investigator, auditor, attorney, or other specialist type of support, such as doctors, nutritionists, et cetera; and, then, they help in obtaining that support.

We have also a team of attorneys in Sacramento that are assigned to deal exclusively with community-care licensing and to insure the enforcement actions that are taken are done on a timely basis, that they are well-documented and appropriate.

This team of enforcement staff has handled over 700 requests for service during their first 11 months of operation.

The auditors and investigators have been directly involved in cases affecting 11,000 residents in facilities. Of course, these 11,000 are not all children.

Our auditors have found operators who incorrectly charged the residents for services, or mishandled their personal moneys in excess of $160,000 in the 11 months.

The investigators have handled 250 cases, over 90 of which involved physical and/or sexual abuse and neglect. And the auditors have reviewed the records of over 130 facilities for financial irregularities.

Now, these are just some of the points that are included in the material that was given to the committee; and it was the director's intent to make sure that everyone knew that we are doing many things in the department to address many of the problems that you are talking about today and that we are not just sitting idly by, and that, in the final analysis, as public servants, we are indeed earning our pay.

Senator Cranston. Does that complete your statement?

Mr. Manriquez. Yes; it does.

Senator Cranston. Thank you very much.

[The prepared statement of Mr. Woods follows:]

PREPARED STATEMENT OF MARION J. WOODS, DIRECTOR, CALIFORNIA STATE DEPARTMENT OF SOCIAL SERVICES

GOOD MORNING, MY NAME IS MARION J. WOODS. I AM THE CALIFORNIA STATE DEPARTMENT OF SOCIAL SERVICES DIRECTOR. I WOULD FIRST LIKE TO THANK SENATOR ALAN CRANSTON AND HIS STAFF FOR INVITING ME TO TESTIFY BEFORE THIS COMMITTEE.

BEFORE I BEGIN TO TALK ABOUT THE ROLES AND RESPONSIBILITIES OF MY DEPARTMENT IN THE AREA OF FOSTER CARE, I WOULD LIKE TO SHARE WITH THIS COMMITTEE SOME OF MY PERSONAL VIEWS ON THE STATE OF FOSTER CARE IN CALIFORNIA AND THE NATION.

FOSTER CARE HAS EVOLVED INTO AN INSTITUTION. LIKE ANY OTHER INSTITUTION, BY DESIGN, IT TENDS TO PERPETUATE ITSELF.

THE FORCES BEHIND ITS SELF-PERPETUATION ARE VARIOUS SPECIAL INTEREST LOBBIES. BY LOBBIES I MEAN PROVIDERS, THE COURTS, PLACEMENT AGENCIES, CHILDREN'S RIGHTS ADVOCATES, AND A WHOLE ASSORTMENT OF OTHERS.

EACH OF THE SPECIAL INTEREST LOBBIES HAVE THEIR OWN AGENDA. I PERSONALLY HAVE SOME CONCERNS AS TO WHETHER THE SPECIAL INTEREST LOBBIES CAN COLLECTIVELY FOCUS THEIR ATTENTION ON THE VERY REASON FOR THEIR EXISTENCE.

THE REASON FOR THEIR EXISTENCE CENTERS ON THE CHILDREN. CHILDREN, WHO IN THIS INTERNATIONAL YEAR OF THE CHILD, ARE ENTITLED TO A CHILDHOOD FREE FROM EXPLOITATION, GREED, FEAR, ABUSE, NEGLECT, AND WORSE YET, A LIFE DEPRIVED OF HOPE.

I FEAR WE HAVE CREATED AN INSTITUTION WHICH PERPETUATES ITSELF DEVOID OF CONSIDERATION FOR THOSE IT WAS INTENDED TO SERVE.

IT WOULD BE UNETHICAL AND IRRESPONSIBLE FOR ME TO STAND BEFORE THIS COMMITTEE AND LEAVE, UNRECOGNIZED, THE MULTITUDE OF HORROR STORIES THAT HAVE BEEN TOLD BY FOSTER CHILDREN WHO HAVE EXPERIENCED FIRST-HAND SOME OF THE INSTITUTION'S FAILURES.

THE HORROR STORIES EXIST AND THEY ARE REAL. EACH HORROR STORY, REGARDLESS OF HOW DEPRAVED IT MAY BE, SHOULD SOUND OFF LIKE AN ALARM FOR THOSE OF US CHARGED WITH THE RESPONSIBILITY OF CARING FOR CHILDREN, WHO BY LIMITED FAULT OF THEIR OWN, FIND THEMSELVES IN A SYSTEM WHICH THEY HAVE LITTLE OR NO CONTROL OVER.

IN MY POSITION AS DIRECTOR OF ONE OF THE NATION'S LARGEST SOCIAL WELFARE DEPARTMENTS, I HAVE HEARD THAT ALARM.

I DO NOT WANT TO BE MISUNDERSTOOD. I AM NOT MAKING A SWEEPING INDICTMENT OF THE FOSTER CARE INSTITUTION. THERE ARE PEOPLE WHO HAVE HEARD THE ALARM. THERE ALSO ARE PEOPLE THROUGHOUT CALIFORNIA WHO, EACH DAY, PROVIDE, IN SOME CASES AT GREAT PERSONAL SACRIFICE, LOVE AND CARE TO THOUSANDS OF CHILDREN. I BELIEVE THEY SHOULD BE GIVEN SOME PRAISE BECAUSE SO OFTEN THEY ARE NEVER GIVEN THANKS FOR THEIR INVESTMENT IN THE FUTURE.

PRAISE SHOULD BE GIVEN TO THE COUNTLESS SOCIAL WORKERS AND PROBATION OFFICIALS WHO EACH DAY FACE THE TEST OF BEING CALLED UPON TO MAKE A DECISION ABOUT A CHILD'S LIFE. SOME APPRECIATION SHOULD BE GIVEN FOR THEIR CONCERN AND COMMITMENT.

PRAISE ALSO SHOULD BE GIVEN TO THE COURTS FOR THEIR EFFORTS IN ATTEMPTING TO MAKE DIFFICULT DECISIONS ABOUT THE FUTURE OF CHILDREN AND THEIR FAMILIES.

AS I SAID EARLIER, FOSTER CARE IS AN INSTITUTION. IN EVERY INSTITUTION, REGARDLESS OF ITS PURPOSE, THERE IS AN ELEMENT WHO WILL, FOR REASONS PERHAPS BEST UNDERSTOOD BY THEM, ABUSE THE SYSTEM AND THOSE THE SYSTEM IS DESIGNED TO CARE FOR.

IN CALIFORNIA, THERE ARE VARIOUS PORTALS BY WHICH A CHILD ENTERS INTO THE FOSTER CARE INSTITUTION.

SOME CHILDREN ARE PLACED INTO FOSTER CARE BECAUSE OF ABUSE OR NEGLECT. IN THESE CASES, PLACEMENT CAN BE MADE BY EITHER LAW ENFORCEMENT OR A COUNTY WELFARE DEPARTMENT'S CHILDREN'S PROTECTIVE SERVICES WORKER. THERE ARE SOME CASES WHERE CHILDREN ARE PLACED INTO EMERGENCY FOSTER CARE FACILITIES BY COURT PROBATION DEPARTMENTS.

IN OTHER CASES, JUDGES ORDER CHILDREN MADE DEPENDENTS OF THE COURTS AND ORDER THEM PLACED INTO FOSTER CARE FACILITIES. THERE ARE CASES IN CALIFORNIA WHERE CHILDREN ARE PLACED IN FOSTER CARE BECAUSE THE NATURAL PARENT NO LONGER WANTS THEM OR CANNOT CARE FOR THEM.

ONCE THE CHILD ENTERS THE FOSTER CARE SYSTEM, IT IS THE RESPONSIBILITY OF THE STATE TO ENSURE THAT FOSTER CARE PARENTS PROVIDE A SAFE AND HEALTHY ENVIRONMENT. IT ALSO IS THE RESPONSIBILITY OF THE STATE TO ENSURE THAT COURT ORDERS ARE MET AS WELL AS THE WISHES OF NATURAL PARENTS.

THE STATE'S BASIC RESPONSIBILITY IS THAT OF THE SURROGATE PARENT. THE STATE ASSUMES THE RESPONSIBILITY OF MEETING THE CHILD'S NEEDS FOR FOOD, SHELTER, CLOTHING AND EDUCATION.

MY DEPARTMENT IS CURRENTLY LOOKING AT WAYS TO DEINSTITUTIONALIZE FOSTER CARE. WE CURRENTLY HAVE A DEMONSTRATION PROJECT WHICH, THUS FAR, HAS SHOWN ENCOURAGING RESULTS. THE PROJECT IS AIMED AT THE ROOT OF THE NEED FOR FOSTER CARE--THAT BEING THE DISINTEGRATION OF THE FAMILY AS A FUNCTIONING UNIT.

WE CALL THE PROJECT'S CONCEPTUAL BASE "FAMILY REUNIFICATION." WE BELIEVE THAT IF WE CAN WORK OUT THE MANY DOMESTIC CONFLICTS ASSOCIATED WITH A CHILD BEING PLACED INTO FOSTER CARE, WE CAN PREVENT, OR LIMIT, THE INSTITUTIONALIZATION OF CHILDREN. WE BELIEVE WE CAN DO THIS BY PROVIDING SUPPORTIVE SERVICES TO A FAMILY IN CRISIS THAT WILL KEEP THE FAMILY FUNCTIONING AND THUS AVOIDING THE NEED TO TAKE A CHILD OUT OF HIS OR HER OWN HOME.

ANOTHER WAY MY DEPARTMENT IS ATTEMPTING TO DEAL WITH DEINSTITUTIONALIZING FOSTER CARE IS THROUGH ADOPTIONS. IF FAMILY REUNIFICATION IS IMPOSSIBLE TO FACILITATE, WE TRY TO MAKE IT POSSIBLE FOR THE CHILD TO BE ADOPTED INTO A HOME THAT WILL PROVIDE AN ENVIRONMENT MEANINGFUL TO ITS DEVELOPMENT.

IF ADOPTION PROVES TO BE IMPOSSIBLE, WE TRY TO MAKE A LONG-TERM FOSTER CARE PLACEMENT.

AS I SAID BEFORE, THERE ARE SOME ELEMENTS WITHIN THE FOSTER CARE INSTITUTIONS WHO HAVE ABUSED, AND IF LEFT UNCHECKED, WILL CONTINUE TO ABUSE THE SYTEM.

THIS YEAR, THE GOVERNOR'S BUDGET CONTAINS $5 MILLION FOR A STATEWIDE 24-HOUR RESPONSE TELEPHONE LINE TO REPORT INSTANCES OF CHILD ABUSE OR NEGLECT. IF THIS SYSTEM BECOMES A REALITY, IT WILL BE AVAILABLE TO REPORT INSTANCES OF CHILD ABUSE OR NEGLECT WHETHER THEY OCCUR IN FOSTER CARE FACILITIES OR IN PRIVATE FAMILY HOMES.

A CALLER WILL BE ABLE TO CALL A SOCIAL WORKER AT ANY HOUR OF THE DAY OR NIGHT. A SOCIAL WORKER WILL THEN TAKE THE APPROPRIATE STEPS NEEDED TO DEAL WITH THE REPORT. DEPENDING UPON THE CIRCUMSTANCES, A CALL TO REPORT ABUSE OR NEGLECT COULD TOUCH OFF AN IMMEDIATE INVESTIGATION BY A SOCIAL WORKER OR A LAW ENFORCEMENT OFFICIAL.

AT THE PRESENT TIME, THE BULK OF OUR SERVICES, AIMED AT PROTECTING CHILDREN FROM ABUSE AND NEGLECT, RESTS WITH THE DEPARTMENT'S COMMUNITY CARE LICENSING DIVISION.

CALIFORNIA LICENSES FACILITIES PROVIDING NON-MEDICAL CARE AND SUPERVISION TO NEEDY PERSONS IN ACCORDANCE WITH THE CALIFORNIA COMMUNITY CARE FACILITIES ACT OF 1973. I WOULD LIKE TO DESCRIBE THE ADMINISTRATION OF THIS PROGRAM FOR YOU, BOTH IN TERMS OF ITS PAST, PRESENT AND FUTURE PROCESSES FOR PROTECTING PERSONS IN THAT SYSTEM.

I WOULD LIKE TO GIVE YOU SOME PERSPECTIVE ON THE PROGRAM IN CALIFORNIA. ABOUT 50,000 FACILITIES ARE LICENSED TO SERVE ABOUT ONE-HALF MILLION NEEDY PERSONS, WHICH IS A COMMUNITY ABOUT THE SIZE OF SACRAMENTO.

THE STATE LICENSES ABOUT ONE-THIRD OF THESE FACILITIES DIRECTLY THROUGH STAFF FROM MY DEPARTMENT LOCATED IN TEN OFFICES GEOGRAPHICALLY LOCATED TO COVER THE STATE. TWO-THIRDS OF THESE FACILITIES, INCLUDING THE MAJORITY OF FOSTER FAMILY HOMES, ARE LICENSED BY 47 COUNTY WELFARE DEPARTMENTS UNDER A CONTRACTUAL AGREEMENT WITH MY DEPARTMENT. THERE ARE ABOUT 14,000 FOSTER FAMILY HOMES SERVING ABOUT 33,000 NEEDY CHILDREN. THE STATE DIRECTLY LICENSES 1,154 OF THESE HOMES AND THE CONTRACTING COUNTIES LICENSE 13,892 HOMES.

IN TERMS OF THE PROCESSES USED IN LICENSING A COMMUNITY CARE FACILITY, THOSE PROCESSES WHICH HAVE REMAINED SUBSTANTIALLY THE SAME SINCE 1973 ARE PROCEDURES WHICH BOTH STATE AND COUNTY LICENSING AGENCIES CARRY OUT TO ENSURE THAT FACILITIES MEET AND MAINTAIN LICENSING STANDARDS. FIRST, IN THE APPLICATION PROCESS, WE REQUIRE PROSPECTIVE LICENSEES TO COMPLETE AN APPLICATION DOCUMENT PROVIDING KEY INFORMATION ON THEIR HOME (FACILITY), THEIR PLAN OF OPERATION, AND THE INDIVIDUALS WHO WILL BE PROVIDING CARE.

WE ALSO REQUIRE THEM TO AGREE TO A CRIMINAL RECORDS CHECK AND SUBMIT A SET OF FINGERPRINTS TO THE LICENSING AGENCY. WE THEN VISIT THEIR HOME OR FACILITY TO ENSURE ITS BASIC ADEQUACY FOR THE TYPE OF CARE THEY INTEND TO PROVIDE AND, IF SO, INSTRUCT THEM TO OBTAIN ANY NECESSARY FIRE CLEARANCES (FAMILY HOMES SERVING SIX OR FEWER AMBULATORY PERSONS DO NOT REQUIRE A FIRE CLEARANCE). WE SEND THEIR FINGERPRINTS TO THE DEPARTMENT OF JUSTICE IN SACRAMENTO.

INCIDENTALLY, ONCE A RECORD CHECK HAS BEEN SUBMITTED, THE DEPARTMENT OF JUSTICE SENDS ANY SUBSEQUENT ARREST REPORTS TO THE LICENSING AGENCY, WHICH ALLOWS US TO MONITOR THE POSSIBLE CRIMINAL ACTIVITY OF ALL PROVIDERS.

AFTER OUR REVIEW OF THE APPLICATION, THE CRIMINAL RECORDS CHECK AND THE REPORT FROM THE STATE FIRE MARSHAL FOR ANY NECESSARY FIRE CLEARANCE, WE MAKE A DECISION ON THE LICENSE. ANYONE WITH A CRIMINAL RECORD, OTHER THAN A MINOR TRAFFIC TICKET, IS PROHIBITED FROM SERVING AS A CAREGIVER UNLESS WE DETERMINE THEY ARE REHABILITATED AND DON'T POSE A THREAT TO PERSONS IN THEIR CARE. WE ALSO DENY A LICENSE TO ANY FACILITY WHICH CANNOT OBTAIN ANY NECESSARY FIRE CLEARANCE.

IF WE DENY A LICENSE, FOR ANY REASON, THE APPLICANT HAS A RIGHT TO AN ADMINISTRATIVE HEARING AND MAY PURSUE A COURT APPEAL OF THE ADMINISTRATIVE HEARING DECISION. IF WE LICENSE THE FACILITY, OUR LICENSING EVALUATOR MAKES A SECOND ON-SITE REVIEW WITHIN 90 DAYS OF THE LICENSE ISSUANCE TO ENSURE THE FACILITY IS IN COMPLIANCE.

ONCE LICENSED, ALL LICENSED FACILITIES ARE SUBJECT TO ON-GOING MONITORING. ALL RESIDENTIAL FACILITIES ARE VISITED AT LEAST ONCE A YEAR FOR REEVALUATION TO ENSURE THEY ARE OPERATING IN COMPLIANCE WITH APPLICABLE LAWS AND REGULATIONS. WE ADDITIONALLY RESPOND TO COMPLAINTS FROM ANY SOURCE, EVEN IF ANONYMOUS, WITHIN TEN DAYS OF THE COMPLAINT, AND THESE REVIEWS USUALLY RESULT IN A VISIT TO THE FACILITY. I SAY "USUALLY" BECAUSE THE NATURE OF COMPLAINTS VARIES WIDELY AND OUR RESPONSE VARIES ACCORDINGLY.

REPORTS OF PHYSICAL ABUSE ARE ACTED ON AS QUICKLY AS POSSIBLE AND NECESSITATE A SITE VISIT WHEREAS COMPLAINTS OF FISCAL IMPROPRIETY WOULD NOT BE AS URGENT OR NECESSARILY REQUIRE A SITE VISIT. THE INITIAL COMPLAINT REVIEW IS, BY LAW, ONLY TO DETERMINE IF THE COMPLAINT APPEARS TO BE SUBSTANTIATED AND IS NOT BASED ON A FRIVOLOUS ACTION OR HARASSMENT TO THE LICENSEE.

IF WE DETERMINE IN THIS REVIEW THE ACTION MAY BE SUBSTANTIATED, WE THEN TAKE MORE FORMAL ACTION WHICH I WOULD LIKE TO EXPLAIN A LITTLE LATER. BASICALLY, THEN, WE MONITOR FACILITIES THROUGH NORMAL ANNUAL VISITS FOR LICENSE RENEWAL OR THROUGH COMPLAINT VISITS. OUR POLICY IS TO MAKE UNANNOUNCED VISITS WHEREVER POSSIBLE. WHEN WE VISIT A FACILITY AND FIND MINOR PROBLEMS, WE CITE ANY DEFICIENCIES AND SET A DATE FOR CORRECTION, PROVIDE THE LICENSEE WITH A COPY OF THAT CITATION, AND CONDUCT A FOLLOW-UP VISIT TO ENSURE THE DEFICIENCY HAS BEEN CORRECTED AT THE END OF THAT TIME.

ALL OF THE PROCESSES I HAVE DESCRIBED HAVE BEEN IN EFFECT IN THE CALIFORNIA COMMUNITY CARE PROGRAM FOR SOME TIME.

I WOULD NOW LIKE TO SHARE WITH YOU SOME ADDITIONAL ACTIONS WE HAVE TAKEN TO PROTECT PERSONS IN COMMUNITY CARE.

WE HAVE IMPLEMENTED A TEAM OF SPECIALLY TRAINED STAFF TO DEAL WITH THE MORE SERIOUS INCIDENTS THAT OCCUR IN A COMMUNITY OF SUCH SIZE AND DIVERSITY. IN JULY, 1978, I APPROVED THE CREATION OF A CLIENT PROTECTION SERVICES BRANCH IN THE COMMUNITY CARE LICENSING DIVISION. THIS GROUP IS

COMPRISED OF INVESTIGATORS, AUDITORS, AND ENFORCEMENT CONSULTANTS. THE CONSULTANTS ARE ASSIGNED TO SPECIFIED CONTRACTING COUNTIES AND STATE LICENSING OFFICES TO ADVISE LICENSING AGENCY STAFF ON A CASE-BY-CASE BASIS REGARDING POTENTIAL ENFORCEMENT ACTIONS. THEIR ADVICE CONSISTS OF TELLING THE LICENSING STAFF WHAT TYPES OF INCIDENTS REQUIRE AN INVESTIGATOR, AUDITOR, ATTORNEY, OR OTHER SPECIALIST SUPPORT (DOCTORS, NUTRITIONISTS, ETC.), AND THEN OBTAINING THAT SUPPORT.

WE ALSO ASSIGNED A TEAM OF ATTORNEYS IN SACRAMENTO TO DEAL EXCLUSIVELY WITH COMMUNITY CARE LICENSING AND ENSURE OUR ENFORCEMENT ACTIONS ARE TIMELY, WELL DOCUMENTED AND APPROPRIATE. THIS TEAM OF ENFORCEMENT STAFF HAS HANDLED OVER 700 REQUESTS FOR SERVICE DURING THEIR FIRST ELEVEN MONTHS OF OPERATION. THE AUDITORS AND INVESTIGATORS HAVE BEEN DIRECTLY INVOLVED IN CASES AFFECTING 11,000 RESIDENTS IN THE FACILITIES.

OUR AUDITORS HAVE FOUND OPERATORS WHO INCORRECTLY CHARGED THE RESIDENTS FOR SERVICES, OR MISHANDLED THEIR PERSONAL MONIES IN EXCESS OF $160,000. THE INVESTIGATORS HAVE HANDLED 250 CASES, OVER 90 OF WHICH INVOLVED PHYSICAL AND/OR SEXUAL ABUSE AND NEGLECT. THE AUDITORS HAVE REVIEWED THE RECORDS OF 130 FACILITIES FOR FINANCIAL IRREGULARITIES.

I WOULD EMPHASIZE ONE FACTOR IN OUR ENFORCEMENT ACTIVITIES WHICH, TO MY KNOWLEDGE, IS UNIQUE IN STATE LICENSING ACTIVITIES. WE ARE ATTEMPTING TO DEVELOP A PLANNED, WELL ORGANIZED SYSTEM TO IDENTIFY PROBLEMS IN OUR COMMUNITY CARE PROGRAM RATHER THAN SIMPLY REACT TO COMPLAINTS AFTER HARMFUL INCIDENTS HAVE TAKEN PLACE. AS AN EXAMPLE, IN COOPERATION WITH THE SOCIAL SECURITY

Administration, we have designed and implemented a Group Locator System which identifies SSI/SSP out-of-home care checks going to unlicensed facilities or facilities which appear to have more residents than their licensed capacity allows. In the future, we plan to explore the possibility for implementing similar systems to monitor other payments of public monies to unlicensed or over-capacity facilities.

In July 1978, I also authorized creation of a unit which monitors county licensing agency operations to ensure they are in compliance with state licensing rules and regulations. This is a system which California used very effectively in reducing our AFDC error rate, a system which was later mandated by the U. S. Department of Agriculture to improve the food stamp program. This licensing evaluation unit will review every large licensing county operation annually and every small licensing county operation biannually.

After their review, they prepare a report of their findings with recommended corrective actions for any operational problems they observed. The licensing county is then responsible for preparing a plan of correction, which is reviewed immediately for sufficiency and reviewed on-site in subsequent formal reviews. We believe this review system will ensure necessary consistency in all licensing agencies while allowing for the identification of potential improvements to our overall program, just as it has in AFDC.

The end result of the improvements we have already initiated and plan to undertake in the future should be increased public assurance that community care facilities provide humane, equitable and efficient care; and that persons who abuse needy persons are promptly and effectively dealt with to the fullest extent of the law.

Senator **Cranston**. Let me turn back to you, Mr. Comrie, first.

The GAO in its testimony described arrangements set up by People's Temple attorneys where, through guardianships, they were able to place children in unlicensed homes.

Are you aware of this situation, and do you think there is a loophole there that needs to be closed?

Mr. **Comrie**. We were very concerned a few years ago, and, in fact, we were excluded from any court hearings. I think what you'll have to understand is that guardianship is a very formal, legal process which has to be gone through and receive a judge's approval before it can happen.

Recently, though, we've been allowed to step into that process, and it was at our urging, to make sure that we do an investigation first.

It wasn't in terms of a People's Temple problem; it was in terms of could we find a permanent home, adoptive home for that child; and in many cases we were finding they were adoptable. We could have moved on an adoptive-type situation versus just going into guardianship in limbo for the rest of the period as a minor.

Senator **Cranston**. Was the guardianship approach used to get around adequate supervision?

Mr. **Comrie**. From what I've read, up north that's what it looks like they were trying to do. That way, they're not required to be licensed.

They also receive a payment, a foster-care payment, even though we had absolutely no authority to review that home. And I think you're onto a point there that we're still working with the GAO on to see what else we can find.

I don't think it's totally open as a problem, because it is a full judicial review.

But, we'll check, and we'll be coming back to you when he testifies later.

Senator **Cranston**. Right.

Earlier this year, there were complaints about occurrences at a residential facility in Los Angeles County called Leroy's Boys Home.

Mr. **Comrie**. Right.

Senator **Cranston**. There were reports of abuse such as children being kicked by staff members, having their skin raked by car keys, and being forced to do physical exercise until they dropped, and so forth.

I understand that DPSS initiated an investigation into the situation, after receiving an anonymous complaint, and that steps were taken to remove 54 children from the facility.

Would you describe how that situation came to the department's attention, what protective action you took, and how frequently similar incidents occur.

Mr. **Comrie**. Well, that was the first one in years that we've had of an instance like that, on frequency; and let me explain that that was a demonstration of how the system does work here and how it can work.

It first came to our attention because we have a 24-hour child-abuse hotline that can be used by the general public for any referral from the community.

We take calls at one central point. We have trained social workers who screen those calls. If it takes immediate police response or social worker response, we go right then; and it doesn't matter what time it is.

In this case, for some reason, the board of directors of the institution, and the director, did not have adequate reporting upward; and a few—I want to make that point very clear: a few of their staff members went bad.

They reacted emotionally in some types of control situations and did hit children.

That is absolutely against every rule and regulation we have. They know that. When it does happen, it's an immediate fireable offense, and it's a prosecutable offense.

By the way, all of those staff members are going through a court process now and are being prosecuted, not only for touching children—they're never allowed to touch them, except to restrain them mildly, to hold them—but they're going through for the fact that they didn't report child abuse.

And that's another thing you may want to look at in a national code is mandatory reporting consistently across the country.

So, in any event, back to the original point: It was immediately picked up by the hotline; we immediately went out jointly with the sheriff's department; we immediately confirmed that not only were there a few staff members, but there was no reporting to their board of directors, who, I might add, includes a number of judges, attorneys, physicians, business people from that community.

They were just as concerned as we were. They agreed to an immediate closure. We removed the children on the spot while they restaffed.

What happened is what I told you the rules are; the staff was immediately fired. They are being prosecuted by the district attorney while the board works on its communication problem to make sure it works in the future.

That is the most aggravated case we've had, in my memory. I've been either chief deputy or director for 5 years now.

But that's how quickly it was remedied.

By the way, no children were permanently hurt, because we caught it fast. What our concern is if you do not catch it that fast, though, it can get out of hand.

Senator **Cranston**. Well, how quickly was it remedied? Some of the press reports indicated that abuses had been going on there for 2 years.

Mr. **Comrie**. Our records and the police records also—some of the press reports, I don't think, were totally accurate—showed that it was restricted to a few of the staff members, and it flared up over a 2- or 3-month period.

It started very slow. It started with an outburst of a child and a staff member striking him back, and then it went a little bit further to standing at attention for a period, which is also against the rules.

And the minute we heard of it, we then closed it down.

But that's typical of our action. There was no question, by the way—I want to point out, too, that didn't come to my attention.

That was closed simultaneous with an announcement to me. The staff felt totally unrestricted. They felt they had the ability to move the children right then and go.

In fact, I found out about it from a newspaper reporter, because the staff was moving the children the minute they got there.

Senator **Cranston**. You indicated that DPSS has a separate unit that investigates problems of institutional care.

Mr. **Comrie**. Right.

Senator **Cranston**. One of the points that various witnesses have made during our hearings is that a need exists for some form of independent monitoring of institutional care, and that often the actual placement worker is not in the best position to handle investigations of institutional abuse problems.

Would you comment on how DPSS began its separate unit for dealing with this problem and how effective you find it?

Mr. **Comrie**. We identified early that in some cases you need a double-check in a system; that in some cases a worker is more concerned with the outcome of the treatment and may overlook in the overall program.

So what we did, we, of course, have the 600 line staff that have a placement caseload of 9,000, plus others supervised at home which far exceed that; but we set up a separate unit, about 3 years ago, of a small group of people who can look at it without the specific children in mind.

And they routinely walk through the facilities; they routinely do program reviews, to make sure that the program is there and it's functioning as it should.

And, by the way, that includes all facilities, any facility Los Angeles County uses.

And, the second point we need to make, we do not use unlicensed facilities, as it was pointed out. And we're very careful of their first State license. And this comes over and above that.

Senator **Cranston**. The Los Angeles Times ran a story last week, just last week, reporting that the executive secretary of the Los Angeles County Federation of Labor has charged that abused children are receiving inadequate care at MacLaren Hall, the Los Angeles shelter for abused and neglected children.

They charged that the facility is overcrowded and suffers from "constant shortages of clothing, towels, bedding, oral hygiene, and toiletry items."

Do you feel that those charges are accurate?

Mr. **Comrie**. No.

And that all evolved because of a dispute between labor and management. In fact, there was a meeting canceled with a labor organizer in the building because there was an outside institutional inspection team there, outside my department, and we thought that was more important for the manager to be with that.

So the union member thought he would teach the manager a lesson by going to the press, because we were slightly overcrowded at one point.

By the way, simultaneous with that press release, the outside institutional inspection team, which has nothing to do with my operation, sent us a letter and said they found everything all right.

We did have a problem, though, with overcrowding.

I do need to make a point very clear here: The county has only one facility for abandoned and abused children. It holds a maximum of 200, of which 130 are in the portion that was referred to in the press.

The other 9,000 children are with foster parents or with private institutions.

When we have a problem in recruiting private institutions or foster parents—and under proposition 13, they have not had a pay increase for 23 months now—we, then, have a backup in MacLaren Hall.

So the side of the hall that holds the 130 jumped up to over 160 on the day the press release was made. There were 30 additional children there.

They were receiving good care, though. It's a pride-of-ownership facility. In fact, if we have time today, your staff will be walking through it with you. It is an open facility.

Coincidental with that, channel 4, which is NBC in Los Angeles, has been running a documentary on what a high quality of care the children get there. There is nothing to hide in that facility. It's a beautiful facility.

What it meant was that in each of the three—six major cottages, when we reached our peak overcrowding, there were not separate bedrooms for four to six children, and they had to sleep in the recreation room on beds.

But, that happens. It's a very real concern on our part. But, our only other option was to place them in an unsuitable placement outside, to return them to a dangerous situation.

The lesser of the two situations and, we felt, for good protection, we should maintain them there, rather than send them into a dangerous situation.

They receive beautiful care there. We have one documentary after another about that institution.

Senator **Cranston**. Thank you very much, and thank you for your helpfulness and for arranging for that visit. Mr. Manriquez, I'd like to ask you a few questions. California is one of the recipients of Federal funds under the Child Abuse Prevention and Treatment Act. The Federal law, as you know, requires that States receiving these funds have a mechanism for the reporting of child abuse and neglect, including abuse or neglect in institutions.

Would you please provide us for the record in writing a description of how California presently meets that requirement for reporting of abuse or neglect in institutions.

Going on to another matter, the GAO has provided me with documents from State files indicating that the State of California had received complaints about the involvement of the Peoples Temple in foster-care placements and the possible conflict of interest in the employment of Marceline Jones—Rev. Jim Jone's wife—in the Department of Health's licensing and certification unit as early as July of 1977.

These documents indicate that the State investigation terminated—despite allegations of all sorts of abuses—in the summer of 1978.

Why was that investigation terminated?

Mr. **Manriquez**. Senator, I'm unable to answer that question.

At that time, the responsibility for all of these programs before was in a department that was called the department of health. We inherited their records. As a result of a reorganization, this department then became responsible for the social service programs, July of last year.

We inherited their records at that time.

Senator **Cranston**. Well, have you made an effort to find out why it was terminated?

Mr. **Manriquez**. Yes; we have. I have talked——

Senator **Cranston**. Did you find out why?

Mr. **Manriquez**. I have talked to the investigator, and he assures me that he had information that there were several Federal agencies that were carrying on investigations about the Peoples Temple allegations, and that he recommended that the State adopt a role of supporting those investigations, rather than carrying on with the investigation that he had going on at that time.

Senator **Cranston**. What Federal investigations?

Mr. **Manriquez**. He mentioned investigations being carried out by the U.S. Postal authorities.

Senator **Cranston**. What would they be investigating?

Mr. **Manriquez**. It's my understanding that there had been allegations made about public assistance warrants being "laundered" through various collection points in the State, and that there was a strong possibility that there was a misuse of U.S. mails involved.

Senator **Cranston**. Did the State contact the Federal authorities and offer to help them?

Mr. **Manriques**. I don't know, Senator.

Senator **Cranston**. I've looked at the report, and, in view of the shocking nature of the allegations, it's rather incredible that the States' investigation would be dropped without any certainty as to what would be carried on in regard to the report.

Mr. **Manriquez**. Yes.

We felt the same way; and, when we saw it, we saw all of the open ends in that investigation; and that's what prompted our department, then, to take on some investigative activities.

However, we did not have responsibility for the program until after July. By the time we got started in our investigation, we had the Guyana incident occur in November; and, then, of course, the emphasis of our investigation then shifted over to that of the Peoples Temple.

Senator **Cranston**. Do you think anything more could be done to find out why that investigation was dropped?

[No response.]

Senator **Cranston**. I'd like to urge you to think that over and——

Mr. **Manriquez**. Yes.

Senator **Cranston** [continuing]. See if you can't find out more on that. Because it's very strange, in view of the allegations. And I wouldn't think that just assuming the Post Office Department was going to look into abuse of the mails would be a very effective way of getting at the bottom of the sort of circumstances that were going on there. And had an investigation continued, things that occurred thereafter might not have occurred.

Mr. **Manriquez**. I can't answer that, Senator.

Senator **Cranston**. Well, you can look into——

Mr. **Manriquez**. Yes; I certainly will.

Senator **Cranston** [continuing]. That and try to find out more about what happened to that investigation.

Mr. **Manriquez**. Yes.

Senator **Cranston**. The GAO report indicates that six of the foster children went to Guyana after October of 1977—when the investigation began—and three of the six went after June of 1978—when the investigation terminated.

The report that was released earlier this month by the House committee investigating the death of Representative Leo Ryan states:

> State Department witnesses said that the U.S. Embassy in Guyana was never asked by California welfare officials to check on the welfare and whereabouts of California foster children reportedly living in Jonestown. The U.S. Embassy, however, was aware that some foster children may have been living there and asked the Department of State to determine whether it was legal for such wards of the State to leave the United States. One department witness stated that he queried appropriate California authorities and was told that Court permission was required to take them out of the state.

Do you have any comment on that?

Mr. **Manriquez**. Yes, Senator.

First of all, I believe that we have to realize that in terms of our department and the involvement of the Aid to Families With Dependent Children foster-care component, we are talking about only a segment of the overall foster care area.

Foster care that might involve legal guardianship and does not involve an AFDC-BHI payment would not come under the purview of our responsibility or our ability to investigate.

The GAO has reported that there was only one child in Guyana that was an active AFDC-BHI case, thereby becoming our responsibility.

If there were 6 children in foster care in Guyana, then, the would have been 6 of that 37, that group of 37 children that were under a legal guardianship type of arrangement, and, thus, would not be within our area of investigation.

As was indicated in his report, there were 19 children that at one point in time had received payments under the AFDC-BHI program. Eighteen of those had been discontinued prior to their arrival in Guyana.

They had been returned to their parents, in most cases, were adopted, or had been placed under some type of a legal guardianship arrangement; which then took them out of the sphere of our responsibility.

Senator **Cranston**. I have a couple of things I would like to ask you to provide just for the record, not to reply to now.

First, could you give us a description of the procedures in California for the establishment of guardianships, including any administrative regulations or guidelines the State has issued.

Second, as you know, Congress is considering Federal legislation to facilitate the establishment of information systems for foster care. California has been implementing such a program.

I would like to get from you information as to what progress you've made, and how your data-collection system on services compares to your data collection on the fiscal side.

That concludes our hearing. I appreciate very much your presence with us, Sister Mary Elizabeth.

Sister **Mary Elizabeth**. Thank you very much, Senator Cranston.

Senator **Cranston**. I thank all of you who have testified this morning, and I thank others of you who have been in attendance for your interest and involvement. I assure you we are going to keep at this and find some way to deal effectively with institutional abuse and do what we can to make necessary reform in foster care and adcption programs.

Thank you very much. We stand in recess.

[Whereupon, at 12:05 p.m., the subcommittee adjourned, subject to the Chair.]

APPENDIX

I. ADDITIONAL STATEMENTS

II. WRITTEN RESPONSES TO QUESTIONS

III. ARTICLES AND RESOURCE MATERIALS

II. Written Responses to Questions

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Human Development Services
Office of the Assistant Secretary
WASHINGTON, D.C. 20201

March 16, 1979

The Honorable Alan Cranston
Chairman
Subcommittee on Child and
 Human Development
United States Senate
Washington, D. C. 20510

Dear Alan:

Thank you for your February 5th letter forwarding several questions raised by you and by Senator Riegle at the hearings on the abuse of children in institutions held by your subcommittee January 24th. Enclosed are responses to those questions.

You also requested in your letter that I report on my commitment to establish an on-going task force with the Civil Rights Division of the Justice Department for the coordination of efforts between HEW and Justice to deal with the problem of abuse of children in institutions. I have set up a meeting between myself, Assistant Attorney General Drew Days, and Barry Van Lare, Associate Commissioner for Family Assistance (HEW), to work out mechanisms for coordinating efforts and planning, because OFA is a major source of HEW's financial support for children in institutions.

In addition I am forming a preliminary work group within the Office of Human Development Services to map out appropriate action and identify required resources. It is too early to be able to specify the costs of this in terms of staff and budget.

In response to your request for estimates on the amount of federal money supporting the care of children in institutions and group homes through HEW programs, the attached table gives the most recent data available.

I share your concern for finding more effective ways to ensure that institutionalized children receiving federal support are not subjected to abuse or neglect. I hope the task force will provide needed impetus for change.

Sincerely,

Arabella Martinez

Arabella Martinez
Assistant Secretary
for Human Development Services

Attachments

HEW Institutional Support for Children (Including Group Homes)

Legislative Authority	Data Year	Type of Care	Amount Spent
Social Security Act			
Title IV-A AFDC-FC	FY '78	Institutional Foster Care	$100 M
		Family Foster Case	113 M
Title IV-B	FY '78	Primarily Family Foster Care (statistics not differentiated)	43 M
Title XIX	FY '76	AFDC eligible	
		Skilled Nursing Home	9 M
		Intermediate Care Facility for the mentally retarded	10.5 M
		Intermediate Care Facility (other)	2.5 M
		Non-AFDC	
		Skilled Nursing Home	3 M
		Intermediate Care Facility for the mentally retarded	20.6 M
		Intermediate Care Facility (other)	.7 M
Title XX	FY '76	Support Services to children in institutions. (Funds go to the institutions). Estimated on basis of percentage of children out of total individuals served.	68 M
Title I, Elementary and Secondard Education Act			
	School year 1978-79	Supplementary Education for children in institutions.	
		State operated	32 M
		non-State operated	17.5 M
		TOTAL	$419.8 M

Senator Cranston:

1. Do you think it is necessary to amend the Child Abuse Prevention and Treatment Act to strengthen the institutional abuse reporting provisions by requiring that reports be made to a centralized agency?

I do not believe that new legislative language is necessary.

In order for a State to receive a grant under Section 4(b) of the Act, present regulations require that a reporting system be in place which, either by law or administrative procedures, requires specified persons to report known or suspected cases of child abuse or neglect to a properly constituted authority and, further, provides for, allows, or encourages all other citizens to report such cases. The regulations are permissive as to what constitutes a properly constituted authority, but require that such be designated and that it not be one that will be in the position of investigating itself.

Because of the importance of avoiding self-investigation and because any of the likely designees such as law enforcement, social service, child protection, and health agencies may also be administering an institution or facility, the flexibility allowed under current regulations is important.

In addition to promulgating that regulation and monitoring its compliance, I believe the Federal role includes encouragement through providing models and technical assistance to the States in carrying out this provision more effectively. The Draft Model Child Protection Act, mentioned in my testimony, provides such a model. In addition, the newly-funded demonstration grants on "Investigation and Correction of Child Abuse and Neglect in Residential Institutions" are expected to provide actual field models that other States may replicate.

I believe both the law and the regulations now contain an adequate basis for addressing the issue of centralized State reporting. The task ahead is fuller State implementation and compliance.

Senator Cranston:

2. Do you think it would be feasible through an amendment to the Child Abuse Act to add a condition that funded States must extend protection from reprisals, such as firing or demotions, to employees in institutions who report abuse or neglect?

It has been our observation, in working with professionals in community settings, that provisions contained in P. L. 93-247, the Child Abuse Prevention and Treatment Act, for immunity in civil suits against those who report known or suspected child abuse and neglect in good faith have served as an important element in increasing the rate of reporting. Similarly, prohibition of adverse actions against residential child care staff who report known or suspected cases could be expected to increase such staff's willingness to meet their legal and professional obligations to report. However, such provisions can not be allowed to insulate employees from acting responsibly. For example, if an incompetent employee about to be separated "reports" abuse of children this should not put the agency in a position of no longer terminating the incompetent person. This is a rather delicate personnel management issue that we believe should not be treated with in detailed federal legislation at this time.

Senator Cranston:

3. Explanation of Four Demonstration Grants on Investigation and Correction of Child Abuse and Neglect in Residential Institutions and the Process of their Selection:

In September, 1978, the National Center on Child Abuse and Neglect awarded four demonstration grants on the "Investigation and Correction of Child Abuse and Neglect in Residential Institutions." Eligibility for these grants was limited to State agencies with the legal authority to make investigations and to take corrective action, on the grounds that this aspect of child protection in residential institutions was a priority area of concern and funding and responsibility should be placed in the hands of agencies with a legal basis for implementing new procedures and necessary changes. The grantees were chosen by a non-Federal peer review panel.

Eleven agencies applied for these grants. In addition to Utah, New Jersey, Massachusetts and the District of Columbia, which were awarded grants, applications were received from Maryland, Louisiana, New York, North Carolina, California and Wisconsin.

As indicated, the grantees were chosen by a review panel comprised of three individuals who are not employed by the Federal government, who possessed extensive knowledge and experience in the area of maltreatment of children and related issues, including knowledge of residential institutions. Each of the eleven applications was reviewed by each panel member and rated narratively and numerically on a form supplied to them by the National Center on Child Abuse and Neglect. Applicants' proposals were reviewed for compliance with all requirements of Child Abuse and Neglect Grants Program Announcements and Guidance, FY 1978 (dated May 19, 1978). A high-to-low score summary was prepared. The highest scoring eligible applicants within the limits of available funds were recommended to the Commissioner, Administration of Children, Youth and Families, for the purposes of award. The Commissioner confirmed the panel and staff recommendations by awarding the four grants.

Senator Cranston:

4. Does H. E.W. have any funds supporting (training) programs for institutional workers?

Yes. Both Title XX training funds and Title IV-B (Section 426) child welfare training funds are used to support the training of child care workers in residential institutions. FY 1979 Section 426 child welfare training grants will allow this funding to train those who license and monitor residential institutions for children. In addition, the Children's Bureau has developed and is now disseminating a curriculum for child care workers (which is described below in response to Senator Riegle's first question).

5. Does H.E.W. have any on-going projects looking into the scope of institutional abuse?

The Clearinghouse of Official Reports on Child Abuse and Neglect, managed by the American Humane Society under contract with the National Center on Child Abuse and Neglect, collects and analyzes reports of abuse and neglect in residential institutions and foster family care which are made to the State departments of social services. These reports are increasing in number as implementation of better reporting structures (required for State grants under the Act) and greater awareness on the part of workers are accomplished.

In addition, we are preparing to solicit public comments on a proposed priority for funding in the Fall of 1980 entitled "Research on the Needs and Resources for Child Protection in Residential Institutions." One suggested option for this research grant program is a study of the feasibility of conducting an incidence study of child abuse and neglect in institutions.

Senator Riegle:

1. One of the problems cited as being a major contributor to institutional child abuse and neglect is a lack of adequately trained child care workers. Would you please discuss any research findings on this topic and what the components are in the curricula the Children's Bureau supported the development of for training child care workers.

Research findings are very meager on the relationship of the lack of adequately trained child care workers as a major contributor to institutional child abuse and neglect. We are aware that there are a growing number of community colleges which have established preservice training courses for residential child care workers. A variety of institutions have developed training course materials for their employees. Recently, recognized pretested course materials have been made available for trainers.

While there are some references in the literature regarding the need for training for child care workers, there remains a significant void as to how training needs relate to the issue of institutional child maltreatment. However, the Subcommittee may wish to review GAD's report on "children in Foster Care Institutions" (HRD 77-40). The Children's Bureau has supported the development and use of curricula for the training of residential child caregivers and foster parents. The "Training Course for Residential Child Care Workers" consists of a basic course design covering 20=36 hours of instruction plus additional enrichment activities. It is a participative and experiential package which includes a combination of exercises and resource materials. It contains 16 booklets including: an Instructor's Guide and Student Guide to the overall course; 7 Instructors' Manuals for specific subject areas, and 7 Student Manuals for the corresponding subject areas.

The 7 subject areas are:

Developmental Planning
Developmental Needs
Separation
The Cottage
Discipline
The Group
The Job

1. Continued

The Instructor's Guide which presents an overview of the entire training course includes goals, principles of instruction, student assessment, teaching strategies, instructor's role, format of manuals, schedule of class hours and resources for instruction.

The Student Guide presents an overview of the entire training course from the student's point of view, describing the 7 Student Manuals, how to use the self-instructional materials, how to apply classroom learning in the cottage and self-assessment activities. The Student Manuals are programmed instruction and can be used independently or as the beginning of a training course. A brochure describing the basic residential child care worker course materials is attached.

Senator Riegle:

2. Given the high percentage of federal dollars that go into financing various child care institutions, what federal sanctions can be brought to bear on institutions violating eligibility standards to receive these funds and how effectively is HEW enforcing these sanctions?

Generally speaking, federal sanctions are against the initial grantee, and the states are limited to withholding funds in cases where a state is found to be out of compliance with state plan requirements, in the law or in the regulations.

For example, Sec. 402(a)(16) of the Social Security Act requires a state plan to: "Provide that where the State agency has reason to believe that the home in which a relative and child receiving aid reside is unsuitable for the child because of the neglect, abuse, or exploitation of such child it shall bring such condition to the attention of the appropriate court or law enforcement agencies in the State, providing such data with respect to the situation it may have."

Section 404(a)(2) provides: In the case of any State plan for aid and services to needy families with children which has been approved by the Secretary of Health, Education, and Welfare, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 402(a) to be included in the plan; the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

These provisions affect Title IV-A programs.

The regulations for Title XX, provide for 'Standards for institutions or foster homes' (CFR 45, 228.12): Where a service plan includes services to individuals living in institutions or foster homes, the State plan shall provide for the establishment or designation of a State authority or authorities, that may include Indian tribal councils on Indian reservations which shall be responsible for establishing and maintaining standards which are reasonably in accord with recommended standards of national standard setting organizations concerned with standards for such institutions or homes including standards related to admissions policies, safety, sanitation, and protection of civil

2. Continued

rights. For purposes of this section, "institution" includes all residential facilities providing for group living.

Section 228.19, 'Noncompliance' provides for the withholding of payments while a state is in noncompliance with any requirements in the law or regulations. The Secretary is given two options -- withholding all payment to a state or 3% of the state's allotment. The text of this regulation is attached.

Title IV-B is unique in that, rather than having a specific provision for disallowances and compliance proceedings, the law and regulations revolve around a jointly developed plan which is in the nature of an agreement. If a state fails to abide by the agreement, the Department, after appropriate proceedings, may hold up further payments.

These programs are all designed to be state-administered, with federal funds matched by state funds. Federal funds go to the state and then to the institution, and the primary responsibility for administration of grants to institutions rests with the state. This, of course, includes state responsibility for investigating suspected cases of abuse. We have not withheld funds from a state because of child abuse in an institution within a state. That should be the primary responsibility of each state.

I do feel, as I indicated in my testimony, that we need to take a much closer look at this situation. As stated in my letter to the Chairman, I am forming a task force with the Department of Justice and the Office of Family Assistance to examine this issue.

[illegible]

United States Senate
COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, D.C. 20510

April 5, 1979

Honorable Drew S. Days, III
Assistant Attorney General
Criminal Division
Department of Justice
Constitution Avenue and
Tenth Street, N. W.
Washington, D. C. 20530

Dear Mr. Days,

I wanted to get back to you to thank you again for the excellent testimony you provided at the Subcommittee's January 24th hearing on the abuse and neglect of children in institutions. Additionally, I would like to follow-up on a number of areas of concern addressed in my questions at the hearing.

First, I agree with you that litigation such as that which would be authorized under S. 10 should not be "the be all and end all" in our efforts to deal with the abuse and neglect of children in institutions.

However, in response to my question concerning the nature and the extent to which the Justice Department (DOJ) and the Department of Health, Education, and Welfare (HEW) coordinate their activities and efforts in this area, you candidly responded that "the nature and level of cooperation had not been what I hoped it would be" and suggested the possible melding of two techniques -- litigation and funding -- as an area where Justice and HEW might work together to find ways to assure that the Federal Government is not financially supporting the abuse and neglect of children in institutions.

At the hearing, you will recall that I asked both you and Arabella Martinez to make a commitment to improve coordination between DOJ and HEW in dealing with this problem. In this regard, I would appreciate your responses to the following questions --

A) Have any specific steps been taken or planned to work with HEW on melding the two techniques, litigation and funding?

B) Have timetables been established for dealing with the problems entailed in Federal funds supporting children in institutions where abuse is found to have occurred?

C) Have any steps been taken or planned to explore possibilities with HEW for curbing abuse through use of the Federal funding process?

A second area of inquiry of extreme importance deals with the protection from abridgement of the constitutional and statutory rights of those institutionalized children who are in private settings, but who are supported in institutional care with Federal funds. You indicated that the coverage of these children under S. 10 would be dependent upon a determination as to whether the support of the child constituted state action. You later specified, however, that the courts had found that, in other areas, financial support did not constitute state action.

I would appreciate your views as to the most appropriate way to proceed in order to assure that, where appropriate, these institutionalized children would be covered under S. 10.

Also, I would appreciate your views as to whether the Justice Department has adequate authority under laws providing for Federal support of institutionalized children (such as Social Security Act titles XX and IV-A), to initiate or intervene in litigation where these children are being abused or neglected.

Again, I appreciate very much your testimony before the Subcommittee and your obvious deep personal concern for the welfare of institutionalized children.

With best wishes,

Sincerely,

Alan Cranston

Alan Cranston
Chairman
Subcommittee on Child and
Human Development

cc: Honorable Arabella Martinez

United States Department of Justice
WASHINGTON, D.C. 20530

ASSISTANT ATTORNEY GENERAL

JUL 6 1979

Honorable Alan Cranston
Chairman, Subcommittee on Child and
  Human Development
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

This is in response to your letter of April 5, 1979 posing several questions regarding activities of the Departments of Justice, and Health, Education, and Welfare on behalf of institutionalized children.

Representatives of the Civil Rights Division and relevant HEW offices met initially on March 16 to discuss creation of an ongoing informal Task Force to address the appropriate nature and scope of cooperative efforts by the Departments. The Civil Rights Division's primary representative in this effort is my Deputy Assistant Attorney General for Policy and Planning, John Huerta. The primary HEW representative has been Gertrude Wright, legislative coordinator for Assistant Secretary Martinez. Mr. Huerta and Ms. Wright have met since that initial meeting to set in motion increased cooperation between the two Departments. For example, a Civil Rights Division attorney has been assigned to review the statutes and authorities under which HEW administers programs serving institutionalized children to increase this Department's familiarity with those statutes.

The issues raised in questions A), B) and C) are among the agenda of items for review by the Task Force. However, the Task Force has not taken any of the specific steps suggested by these questions.

You also inquired about how S. 10 might cover children residing in private institutions but supported with Federal funds. The most appropriate way for the Senate to express such an intention would be action to modify S. 10 to contain appropriate explicit statutory language.

The Department of Justice has consistently contended that it has the authority to sue to enforce statutorily defined policies and conditions attached to the award of federal grants. This contention has been repeatedly recognized in the federal courts. The Task Force has begun a review of the statutes authorizing relevant HEW grant programs which will enable us to evaluate whether the particular conditions of such grants may in some circumstances authorize litigation to vindicate the rights of children in recipient institutions.

I hope you will consider this an interim response to your inquiries pending further work by the Task Force to clarify many of the issues in your subcommittee's consideration of this subject.

Sincerely,

Drew S. Days III

Drew S. Days, III
Assistant Attorney General
Civil Rights Division

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN RESOURCES
SOCIAL REHABILITATION ADMINISTRATION
WASHINGTON, D. C.

The Honorable Alan Cranston
Subcommittee on Child and Human
  Development
Committee on Human Resources
United States Senate
Room 4230
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Cranston:

This transmits responses to questions posed by you and by Senator Riegle following the hearings before the Subcommittee on Child and Human Development on the subject of Child Abuse in Residential Institutions.

I very much appreciate being afforded the opportunity to testify before the Subcommittee. I hope that the hearings and your other efforts in this regard will hasten the time when the experience of all those children who must spend a portion of their youth away from their families will at the very least be safe and humane.

Sincerely,

William W. Barr
WILLIAM W. BARR
Administrator

QUESTIONS FROM SENATOR CRANSTON:

1. a. At page 2 of your written testimony, you indicate that you are "responsible not only for protecting the welfare, the rights, and the mental and physical health of the youth committed to the Department's care, but also for guiding and monitoring the actions, preventing or assuring disciplinary action for the sins of omission and commission and protecting the rights of staff who work in the institution." How are you able to reconcile these roles -- protecting the rights of committed youths and protecting the rights of staff?

Reconciling the role of protecting the rights of committed youths and protecting the rights of staff involves a balancing act on the part of the Administrator of the Social Rehabilitation Administration. This is true in any situation in which a single administrator or hearing officer must make decisions in an atmosphere which guarantees due process to parties whose interests are at times in conflict with each other.

It is not possible, nor indeed would it be desirable, to convene a full hearing, with counsel on both sides, and requiring the services of a judge to preside in each case in which there is an accusation by a child of a staff member or vice versa in one of the institutions. These decisions must be made in an administrative hearing situation, with as much awareness of the necessity to be fair (and to appear fair) to both sides as possible. My personal training as an advocate in social work and as a manager have been invaluable in this regard.

The other way in which these protections can be increased is by building into the system as many devices as possible to guard the rights of all of the "actors" in the institutional setting. The input which will be gained from the demonstration project will be extremely important in this regard, since it will show us whether such a "direct complaint" system would have value as a permanent feature of the system at our institutions.

b. What qualifications are needed for an individual to be eligible for employment in D.C. as a child care worker?

At the present time, Institutional Counselors, who perform the basic child care function in the Institutional Care Services Division institutions, are employed through the Federal Civil Service System with entry grade GS-301-5.

The following material is excerpted from the most recent Merit Promotion Announcement for Institutional Counselor.

Duties in Brief: Assumes the responsibility for the supervision of residents and for carrying out established programs on a tour of duty in a unit, cottage or for a group of residents. Supervises prescribed work details and leisure time activities in the unit, playgrounds or work areas. Counsels individual residents on behavior problems, sets up behavior limits, advises them on personal problems. Is responsible for writing descriptive reports of unusual incidents or events occurring on tour of duty. May be required to chase or assist in the chasing of absconders. Responsible for carrying out security measures.

Qualifications: Applicant must have three years of experience (two years general and one year specialized). General Experience is experience in any type of work which involved dealing with others, and which demonstrated the applicant's aptitude for developing the personal qualities and acquiring the particular skills and knowledges needed for the position. Specialized Experience is experience, paid or voluntary, full or part time, which has demonstrated that the applicant has acquired and is able to apply the knowledges, skills, and abilities appropriate to the particular nature and grade level of the position. The experience must also demonstrate the ability to communicate effectively with members of the group served, win their respect and confidence; work effectively with specialists on the staff and others in helping encourage and motivate program participants; and apply a practical understanding of some of the methods and techniques of counseling.

Education above high school level may be substituted. At least 1 year of the required experience must have been comparable in difficulty and responsibility to the GS-4 level of which at least 6 months must have been specialized experience. Must have Civil Service status and/or appropriate notice of Rating.

QUESTIONS FROM SENATOR RIEGLE

1. In your locked box experiment, once a child has submitted a claim of abuse or neglect, what is done to protect the child during the course of investigation? And, what action is taken against staff member(s) alleged to have abused or neglected the child while under investigation?

   There are several options available to protect youth who may be in danger of being further abused as a result of having submitted a complaint. They mostly stem from the fact that there are three institutions administered under the Social Rehabilitation Administration, two of them rather large, with a number of different cottage placements. It is possible to change the child's cottage or institutional placement if either the child or the investigating officer feels that there is a danger of retaliation. It is also possible, if the evidence warrants, to change the staff member's cottage or institutional placement during or following the investigation.

   In addition, it has been our experience with other investigations over the years that the mere knowledge that a case is being investigated by an outside body has tended to serve as a protection for the child involved.

   An allegation that a staff member has abused a child while under investigation would be treated as a separate case of abuse, and would call for an additional investigation. Sanctions imposed on staff found to have mistreated a child while under investigation would range from warning to dismissal, as appropriate.

2. Will counseling be provided under your grant to work through problems arising on a case-by-case basis, or is it intended to be an ongoing form of training for staff and sensitizing them to the special needs of the children they work with? Will children be involved in any of the counseling sessions?

   For the first funding year, the Advanced Counseling Groups will concentrate on general sensitizing of the institutional staff, using a psychodrama format. There will not be a consideration of individual cases, except insofar as they are selected by the group for reenactment by psychodrama.

   Depending upon the effectiveness of this tool, the counseling component in future years may involve more counseling on a case-by-case basis, possibly involving both the staff member and the child.

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United States Senate
COMMITTEE ON HUMAN RESOURCES
WASHINGTON, D.C. 20510

February 21, 1979

Mr. William W. Barr
Administrator
Social Rehabilitation
  Administration
Department of Human
  Resources
122 C Street, N. W., Room 800
Washington, D. C. 20001

Dear Mr. Barr,

Thank you very much for testifying before the Child and Human Development Subcommittee. Your testimony was very helpful to me in learning more about this very difficult problem.

As we indicated at the hearing, both Senator Riegle and I have some additional questions for you. I am enclosing a copy of these questions, and would very much appreciate your getting the responses back to us within two weeks. I am enclosing a self-addressed envelope.

Cob
3/9/79

Again, I appreciate very much your taking the time to testify and your contributions to our hearing.

Sincerely,

Alan Cranston

Alan Cranston
Chairman
Subcommittee on Child and
  Human Development

Enclosures

cc: Senator Donald W. Riegle, Jr.

SEN. CRANSTON - Questions to Witnesses at Institutional Child Abuse Hearing

William W. Barr, Administrator, Social Rehabilitation Administration, Department of Human Resources, D.C.

1. At page 2 of your written testimony, you indicate that
you are "responsible not only for protecting the welfare,
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guiding and monitoring the actions, preventing or
assuring disciplinary action for the sins of omission
and commission and protecting the rights of staff who
work in the institution". How are you able to
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committed youths and protecting the rights of staff?
What qualifications are needed for an individual to
b be eligible for employment in D.C. as a child care
worker?

SEN. RIEGLE - Questions to Witnesses at Institutional
Child Abuse Hearing

William W. Barr, Administrator, HEW Grant for Research
into Institutional Child Abuse, D.C.

1. In your locked box experiment, once a child has submitted a claim of abuse or neglect, what is done to protect the child during the course of investigation of the complaint? And what action is taken against staff member(s) alleged to have abused or neglected the child while under investigation?

2. Will counseling be provided under your grant to work through problems arising on a case-by-case basis or is it intended to be an on-going form of training for staff and sensitizing them to the special needs of the children they work with? Will children be involved in any of the counseling sessions?

3. Are there any structured educational programs for the children in the D.C. residential institutions?

FINAL REPORT

Grant Title: "The Development and Implementation of Policies and Procedures for Intervention in Cases of Child Abuse and Neglect in Institutions"

Grant Number: N-2C76-B

Awarding Agency: U.S. Department of Health, Education and Welfare, Office of Child Development

Submitting Agency: State of New Jersey
Department of Human Services
Division of Youth & Family Services
Greg Smiles
Institutional Abuse Coordinator

INTRODUCTION

This report outlines the activity that occurred during the above titled grant's existence. The grant's existence covers the period from March 27, 1978 to December 31, 1978, a term of approximately nine months. The grant essentially involved the establishment of the Institutional Abuse Coordinator's position. The following report outlines the key areas that were addressed during this nine month period.

INTER-DIVISIONAL GUIDELINES ON REPORTING INSTITUTIONAL CHILD ABUSE

The philosophy behind the guidelines is that they describe the reporting requirements of institutional abuse to institutional employees, as well as give a framework of what incidents should be reported to DYFS. The intent was to insure each employee had at least seen the guidelines. Although this has not been carried out, recent meetings with the Department of Corrections and the Division of Mental Retardation have reemphasized the need for each employee to see them and the Coordinator has received tentative commitments of cooperation toward this goal. A similar proposal will be made with the Division of Mental Health and Hospitals.

The process of finalizing these guidelines has been difficult and time consuming. We have met with some resistance from the various divisions/departments but through increased communications with them, we are making progress in resolving problem areas.

Guidelines with the Department of Corrections were finalized in August of 1978, after many meetings with correctional personnel. A finalization date for guidelines with Division of Mental Retardation has been set for the middle of March 1979.

The content of the guidelines with the Division of Mental Health and Hospitals was finalized before the Coordinator had started in March of 1978. As of December 1978, DMHH had informed me that the implementation had not occurred. A meeting to attempt to resolve this issue will be held in the first quarter of 1979.

County Guidelines

Guidelines with Essex County have not been finalized to date but efforts to finalize these will be made through the Division's Metropolitan Regional Office.

These guidelines will provide a good base for the establishment of model guidelines to be proposed to each individual county.

Review of Divisional/Departmental Procedures on Institutional Abuse

In July of 1978, the Coordinator circulated proposed changes in the Department's Administrative Order on Institutional Abuse within the Division. Comments were received and were then proposed to the Department for an informal review. The Order was never formally revised because of potential administrative changes. Such changes included redefining the Department of Public Advocate's role in investigating DYFS facilities, the appointment of the Special Assistant to the Commissioner on Children's Residential Institutions and Divisional organizational changes.

However, early in the first quarter of 1979, an extensive review of Divisional procedures is being done and proposed changes will be made. In actuality, however, not many changes need to be made (besides agency organizational changes), but rather the field needs to be reminded of the current procedures and the law.

In December, the Coordinator proposed the implementation of a format for writing institutional abuse reports. The responses from the field have been favorable and it is hoped it will be implemented once revised divisional procedures are finalized.

Training and Related Issues

In June of 1978, two workshops for investigating caseworkers were held. The design of the workshops was that representatives from the Department of Corrections, Division of Mental Retardation, Division of Mental Health & Hospitals and the DYFS Bureau of Residential Services gave presentations describing the facilities they operate, the type of child they care for, what they think of DYFS conducting investigations in their institutions, etc. In addition, there was a general discussion with the caseworkers on their needs surrounding institutional abuse matters. There were approximately 25-30 people at each workshop. The Coordinator wrote and distributed, at the workshop, a three page guide to be used as an aid in conducting institutional abuse investigations. Additional training of this type was not conducted due to agency organizational reasons.

From October to December of 1978, the Coordinator and a consulting psychologist conducted eight training sessions in various residential institutions. The content of the sessions consisted of describing the child abuse law (reporting requirements and what constitutes abuse/neglect) and ways to manage children with non-abusive techniques. The training was given to line staff and the feedback received was very positive. Such training will be a key component in New Jersey's new project.

Throughout the project, the Coordinator made himself available to DYFS and non-DYFS personnel for any technical assistance needed on institutional abuse matters. While most of this involved DYFS workers (conducting investigations), it is also meeting with institutional agencies on specific issues (i.e. discussing a facility with repeated allegations of abuse and developing ways to stop it). A substantial amount of the Coordinator's time was spent in this activity which proved to be beneficial in terms of explaining institutional abuse procedures.

The Coordinator also met with various non-institutional agencies for the purpose of explaining issues around institutional abuse. Such agencies included the Department of the Public Advocate (3 offices) and private citizens groups. In addition, the Coordinator participated in a workshop during a conference on children's rights in out of home placement.

Conference

On October 23rd, 1978, the statewide conference on institutional abuse was held at Rutgers University Medical School. The Coordinator was the organizer of this conference. The Conference was attended by 146 people of various professional levels and fields including child care workers, institutional administrators, child advocates, law enforcement personnel and DYFS caseworkers. Evaluations of the Conference have indicated that it was informative and that an annual conference on institutional abuse should be held. The Coordinator viewed this event as a major effort to bring about further awareness of the problem.

The Occurrences of Institutional Abuse Incidents in 1978

Table 1

Table 1 shows the number of allegations that were investigated in 1978, according to facility category. The total number of 122 is 52 more than the number recorded in 1977. It should be noted here that while 122 have been investigated, there are still 7 known investigations that have not yet been received by the Project (investigations not yet finalized). In addition, there is the possibility that there are others still pending which may yet come in that have not been reported to the Office of Child Abuse Control. Therefore in total, there were at least 129 allegations made in 1978, almost a 100% increase over 1977. Only the 122 allegations were used in the table since their outcomes (substantiated or unsubstantiated) are known.

Percent which were Critical - Essentially this includes the number of incidents of institutional abuse or neglect that were substantiated in 1978. However, such a matter-of-fact figure could be misleading and inclusive. Therefore, this category not only includes the number of investigations which clearly substantiated abuse but also the investigations where "concern" was raised with the facility as it pertains to the particular incident. These "concerns" were pointed out in the covering memo of the investigation and approved by the approriate authority (i.e., Administrator of Program Support (DYFS), DYFS Director, Commissioner of the Department of Human Services).

The "concerns" are broken down into the following criteria:

1) Excessive force (corporal punishment, etc.) but substantiated physical abuse.

2) Child had bruises but investigation could not substantiate origin.

3) Child not harmed but potential of harm is there due to inadequate staff supervision.

4) Child injured or harmed (emotionally, socially, educationally), not due to intentional staff abuse but because of lack of proper programming by the facility.

(Most "concerns" were of number 1 nature)

Percent Requiring Follow-Up - In an attempt to more stringently evaluate the seriousness of the incidents, this category involves the percentage of investigations which required the supervising agency of the facility to report back on what actions were taken to remedy a specific incident. While this category usually involved the cases which were substantiated, it also included some cases which were critical but not substantiated. (i.e. continual use of excessive force, lack of supervision, etc.)

Figure 1

Figure 1 shows the number of abuse incidents which occurred according to the month. It does not appear one month is any more abusive than another but shows the average number of investigations processed each month.

Two other statistics which were computed and which will be observed more closely in the new project are:

1) In 52 allegations of 1978 (excluding day care and schools), the time the incident allegedly occurred was known. The time was broken down into the following two categories:

6:00 A.M. to 3:59 P.M.	4:00 P.M. to 1:00 A.M.
Amount: 14	Amount: 38

73% of these 52 incidents occurred between 4:00 P.M. and 1:00 A.M.

2) Mean age of child allegedly abused while in a facility:

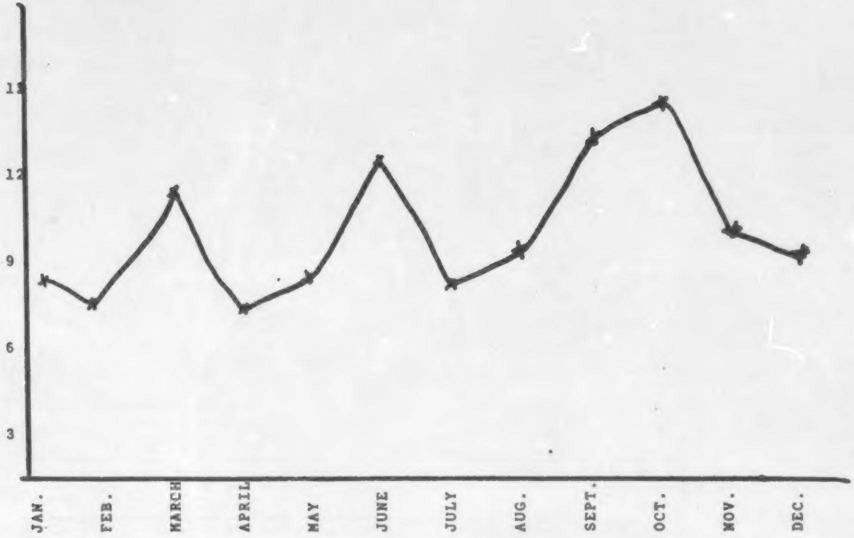
	Mean Age	# of cases where age was known
1) Facilities for Mentally Retarded	12.5	21 out of 24 total
2) Mental Health Hospitals/ Facilities	13	3 out of 4 total
3) State Correctional Facilities	14.3	4 out of 5 total

4) Schools	8.8	5 out of 5 total
5) Residential Treatment Center	14.2	25 out of 35 total
6) JINS Shelters	13	8 out of 10 total
7) Day Camps	8.4	5 out of 5 total
8) County Detention Ctrs.	14.6	12 out of 15 total
9) Day Care	4.1	18 out of 19 total

TABLE 1

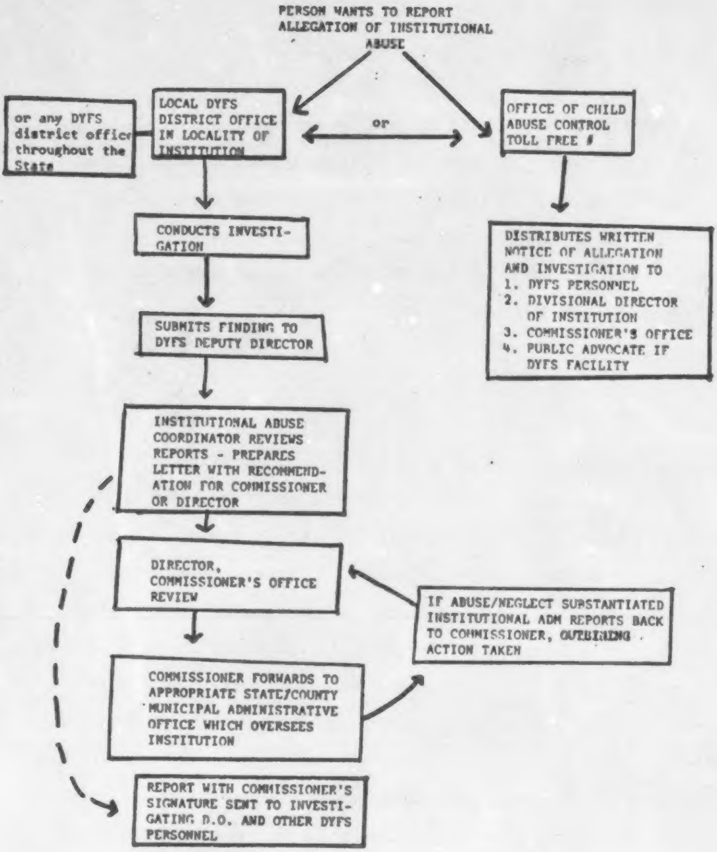
	No. of Allegations Investig.	% which were crit.	% Requir. Follow-Up
Residential Treatment Ctrs.	35	66%	40%
County Detention Centers	15	53	27
JINS Shelters	10	80	60
Facilities for the Mentally Retarded	24	67	33
Mental Health Hospital/Fac.	4	25	25
State Correctional Facilities	5	60	40
Day Care	19	42	37
Day Camps	5	40	20
Schools (non-residential)	5	40	20
TOTAL	122	58%	36%

Figure 1 - Incidents Investigated Per Month 1978



$\bar{X}$ = 10.2

Unknown - 6


PERSON WANTS TO REPORT ALLEGATION OF INSTITUTIONAL ABUSE
or any DYFS district office throughout the State
LOCAL DYFS DISTRICT OFFICE IN LOCALITY OF INSTITUTION
or
OFFICE OF CHILD ABUSE CONTROL TOLL FREE #
CONDUCTS INVESTIGATION
DISTRIBUTES WRITTEN NOTICE OF ALLEGATION AND INVESTIGATION TO
1. DYFS PERSONNEL
2. DIVISIONAL DIRECTOR OF INSTITUTION
3. COMMISSIONER'S OFFICE
4. PUBLIC ADVOCATE IF DYFS FACILITY
SUBMITS FINDING TO DYFS DEPUTY DIRECTOR
INSTITUTIONAL ABUSE COORDINATOR REVIEWS REPORTS - PREPARES LETTER WITH RECOMMENDATION FOR COMMISSIONER OR DIRECTOR
DIRECTOR, COMMISSIONER'S OFFICE REVIEW
IF ABUSE/NEGLECT SUBSTANTIATED INSTITUTIONAL ADM REPORTS BACK TO COMMISSIONER, OUTLINING ACTION TAKEN
COMMISSIONER FORWARDS TO APPROPRIATE STATE/COUNTY MUNICIPAL ADMINISTRATIVE OFFICE WHICH OVERSEES INSTITUTION
REPORT WITH COMMISSIONER'S SIGNATURE SENT TO INVESTIGATING D.O. AND OTHER DYFS PERSONNEL

SUPPLEMENTAL TESTIMONY

USE OF OMBUDSMAN IN JUVENILE INSTITUTIONS

During the testimony at the recent U.S. Senate Sub-Committee Hearings on Abuse of Institutionalized Children, held on January 4, 1979, in San Francisco, Senator Alan Cranston asked that certain supplemental information be provided to the Subcommittee about the use of an ombudsman in juvenile institutions.

In New York State, as a result of the 1974 federal district court decision in the Martarella v. Kelley case which dealt with conditions in New York City's secure detention facility, known as Spofford, the parties entered into a stipulation authorizing the implementation of an ombudsman program. The rationale for the program as stated in the stipulation was that "despite the best efforts of administrators to develop responsive systems to ensure that children who are involved in the judicial process are treated in a positive way, the structure often appears slow to react, unresponsive and impersonal." The ombudsman specifically was authorized to provide to children held in detention access to a mechanism for resolving complaints separate from the established structure. To accomplish this purpose, the ombudsman was authorized to investigate and give prompt attention to facts brought to him by the children relating to the detention program, to legal representation and to program activities.

The ombudsman was to be appointed by an ombudsman review board which had also been agreed to as part of the stipulation in Martarella. Included in the review board were the director of the New York City welfare department's Bureau of Institutions and Facilities, a representative nominated by the private foundation sponsoring the ombudsman program, and not less than two nor more than three adult persons independent of the welfare department and the funding organization who were to be nominated by the Commissioner of Human Resources (i.e. the head of the welfare department). This ombudsman review board would thereafter meet with the ombudsman on a regular bi-monthly basis. Reports of all non-routine investigations were to be regularly forwarded to the ombudsman review board by the ombudsman and the advice and assistance of the board was to be requested as necessary. Decisions of the board were to be made by a majority vote of all the members. After private funding from the particular foundation source ended, the welfare department would determine a new form of payment to carry out the ombudsman program. Also included in the stipulation were provisions for qualifications of the ombudsman, term of office, staff, office space, powers of investigation, resolution of complaints, and complaint guidelines and procedures.

The ombudsman program as it has operated in the secure detention facility since the Martarella decision, has one major and overriding shortcoming which seriously circumscribes its effectiveness. The ombudsman is not and was not ever, pursuant to the stipulation in Martarella, independent of the public agency which operated the secure detention facility. Ultimate decision-making and ultimate rule-making are in the hands of the defendant welfare department officials. The result is that the ombudsman oftentimes has been stymied in attempts to correct problems existing in the secure detention facility. This has been the case despite the fact that for the first three years of its operation, the ombudsman program had as its chief staff member, an individual to whom the juveniles (at the facility) related well, and a person who was highly regarded by many staff members at the facility as well as individuals within and without the welfare department. (That person left the ombudsman program and in fact subsequently became the director of Spofford. There is some question as to whether the successor manifested equivalent skills.) The commonly held view, therefore, is that the ombudsman in the New York situation was only as good as the individual holding the position, but that in any event, the nature of the overseeing agency, the defendant welfare department, mitigated against successful intervention by the ombudsman at the secure detention facility.

The evidence gained from the Spofford situation is that the introduction of an ombudsman system into a childcare institution requires that the ombudsman be independent of the agency operating the facility as well as independent of any outside interested organization. Furthermore, specific guidelines and procedures and reporting systems are necessary, and the reports must be open to wider scrutiny than simply the agency personnel and the parties to the court action.

In Texas, in the case of Morales v. Turman, an ombudsman was similarly appointed as an outgrowth of litigation regarding the state training schools for juvenile offenders. In this case, however, the federal judge appointed the ombudsman in a court order rather than there being a stipulation between the parties. Although the litigation was concerned with five institutions, the ombudsman was appointed only with regard to one of them, known as the Mountain View State School for Boys. The ombudsman himself had been the Chief of Casework Services at the Mountain View institution, and had testified at the trial of the action regarding some of the constitutional and statutory violations of juveniles' rights which had occurred there.

The duties of the ombudsman were twofold. First, to report to the Court "any matters concerning the operation of the Mountain View facility which should be brought to the court's attention, especially any violations of this court's order." Second, to make "such recommendations [to the state agency] as are appropriate concerning the operation of Mountain View . . . especially recommendations concerning compliance with this court's order." In practice, the ombudsman was able to perform the first duty quite well, and copious reports were sent to the court and to the parties from time to time as a result of investigations and inquiries which he made. As for the second duty, however, the state agency appeared quite unwilling to heed any of the ombudsmans' recommendations, and that facet of his work rapidly became relatively unimportant in comparison with the reporting facet.

Unlike the ombudsman in the Martarella case, the ombudsman in Texas did have independence from the state agency. Nevertheless, he suffered under a severe handicap which he could never successfully overcome because it was inherent in his position. Regardless of the seriousness of any matters which he uncovered and reported, he could take no action. His only role was to report the matters to the court and, if he wished, to the parties in the case. After making his reports, it was left to the court and to the parties to take any action on the reports, but this of course could only be done through formal court proceedings unless the state agency were willing to act voluntarily. Moreover, in view of the fact that the ombudsman was dealing with juveniles who were committed to the custody of a state institution, issues of confidentiality and privilege precluded him from taking matters to the public as is apparently sometimes the practice of the ombudsman in some European countries. In any event, his mandate from the court did not authorize such public disclosure.

As with the ombudsman in the Martarella case, one of the main reasons that the ombudsman at Mountain View was effective at all stemmed from his own personal abilities and determination. He continuously exhibited a sincere concern for the juveniles in the institution, and he worked diligently to discover and disclose abuses as they occurred. However, he was apparently viewed as a turncoat by his former co-employees, and he received no encouragement from the institution's staff nor from the state agency. In fact, when the court of appeals reversed the lower court's decision on a procedural ground, the ombudsman was immediately fired by the state agency.

In summary, from our relatively limited experiences, an ombudsman in an institutional setting seems to be able to perform a valuable role, if given sufficient authority, in disclosing abuses which might otherwise go unreported in child-care institutions. However, regardless of how the ombudsman's duties are structured, there is little basis to hope that an ombudsman program can actually be expected to correct the abuses that are uncovered. Something more than an ombudsman is required if the abuses are to be corrected and prevented in any systematic way.

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RESPONSES TO QUESTIONS DIRECTED BY SENATOR ALAN CRANSTON TO MARION WOODS (MAY 31, 1979)

Question 1	Provide a description of how California meets that (federal) requirement for reporting abuse or neglect in institutions.
Answer:	California statutes currently deal with reporting child abuse and neglect cases in general and set forth a system involving four jurisdictions: (1) county welfare departments, (2) local probation departments, (3) local law enforcement agencies, and (4) county health departments. Within the framework of these statutes the state has administratively developed reporting systems dealing specifically with children in out-of-home care. These reporting systems, although sufficient to comply with federal standards, are complex and lack the security of a sound statutory base. Legislation (Assembly Bill 1773) to rectify this situation is being considered by the State Legislature. The legislation is based upon recommendations emanating from the San Francisco project you have mentioned. In regard to investigating reports of child abuse, the state's Community Care Licensing Division and local agencies under contract investigate reports of institutional abuses occuring in facilities licensed through our jurisdiction and take appropriate enforcement/corrective actions.
Question 2	Why was the investigation terminated?
Answer:	The investigation report dated June 6, 1978, recommended closure since, as a result of Senate Bill 363, the Department of Health ceased to exist on June 30. As of that date, the Special Investigation Unit, to which the investigating officer was assigned, also no longer existed. This is the reason why the entire case file was left with the Division of Social Services which became a part of the Department of Social Services on July 1. The investigation report concluded " . . . to continue this investigation without the aid of the United States Bureau of Special Consular Services would involve extensive time and money, as well as a duplication of investigative services." The report recommended " . . . that this investigation be closed and that we extend help and cooperation to those federal agencies currently investigating JIM JONES and the PEOPLES TEMPLE."
Question 3A	Did the State take any action following termination of this investigation to alert counties about its findings?
Answer:	After receiving the subject investigative report, telephone discussions were held with Mendocino County officials. An all-county alert was not issued because concerned counties had been informed of Peoples Temple activities before and during the course of the investigation.

Question 3B What followup activities did the State undertake after its investigation terminated?

Answer: Shortly after completion of the Department of Health investigation, a report dated June 6, 1978, was delivered to the Deputy Director in charge of the Social Services Division. Staff of that division immediately reviewed the report and concluded that none of the children named in the report were in situations which would place them under the jurisdiction of division programs. Concurrently, the report was referred to the Department of Social Services's legal staff. In mid-June an attorney on that staff telephoned officials in Mendocino County to discuss the report and inquire about related investigations carried out by that county. In early July the same attorney contacted the Freedom of Information Office and the U.S. State Department. The State Department was requested to furnish the names of U.S. citizens living in Guyana but was unable to provide the information. Also in July, the report was reviewed by the head of the Department of Social Services' licensing division. This review concluded that no specific licensing issue was involved.

At the request of the licensing division, the staff of the department's welfare fraud prevention unit asked Mendocino county welfare officials for the names of children from the county receiving aid under the AFDC-BHI program which had been taken to Guyana by the Peoples Temple. Mendocino County could not identify any such children. The extent to which allegations contained in the report could be legally pursued was debated within the department for some time following these reviews. The fact that Peoples Temple operations were now located in a foreign country and the department's inability to obtain the names of Jonestown residents, seriously limited the utility of actions which the department could take. Because of these obstacles, there evolved a posture of relying upon the activities of federal agencies which, according to the subject report, were investigating Peoples Temple activities and, in fact, participated in the Department of Health's investigation.

Shortly after the Jonestown tragedy, lists of persons allegedly living in the Peoples Temple commune in Jonestown, Guyana, became readily available from the U.S. State Department and the Peoples Temple organization. The availability of this information made it possible in December for the Department of Social Services to initiate a comprehensive review of state and county welfare records to identify children and adults who may have come under the jurisdiction of its programs. As a result of this review, it has been determined that the department had no legal control over any of the children living in Jonestown at the time the Department of Health concluded its investigation or at any time thereafter. The Department of Health's investigative report and other information was referred to the State Attorney General for investigation on March 2, 1979.

Question 5	Provide a description of the procedures in California for establishment of guardianships, including any administrative regulations or guidelines issued by the State.
Answer:	California Probate Code 1400 et seq. establishes the procedures for appointing a guardian of a minor. In essence, the California Legislature has established a judicial proceeding by which a Superior Court judge determines whether or not a guardianship is necessary. The judicial process is begun when the nonrelative files a petition with the Superior Court. A copy of the petition is forwarded to the Department of Social Services. In those situations where an adoption petition has not been filed, the department contacts the appropriate county personnel so they may perform the required study. This procedure is described in Probate Code 1440(b) and 1440.1. The department's responsibli[illegible] when an adoption petition has been filed will be outlined later.

Prior to making a judicial determination the Superior Court judge may request that an additional investigation be conducted by the county probation officer (see P.C. 1443). In addition, Social Services Letter No. 76-2, issued November 26, 1976, by the Department of Health, requires officials, probation officers, or social workers to investigate the "suitability" of the guardian.

Once the court makes the determination that a guardianship is necessary, physical custody and control of the minor is granted to the petitioner. It should be noted there is no statutory scheme which requires a review of the guardianship of a minor, unlike incompetent or insane persons (P.C. 1500.1). However, The Superior Court does retain jurisdiction and may require periodic review of the guardianship. Guardianship over the minor continues until the child reaches majority or marries (P.C. 1500).

In those situations in which an adoption petition has been filed, the department plays a more substantial role. Before discussing the role of the department in a guardianship when an adoption petition has been filed, it is necessary to distinguish between the two types of adoption procedures in California. In an independent adoption, the parent has directly placed the child for adoption with a person or persons whom he/she knows. The department's role in this situation is limited since the parent has freely given his/her consent to the adoption. If a guardianship petition has been filed before the adoption is completed, the department will inform the Court through a report that an adoption petition has been filed and that the guardianship should be denied. A denial is recommended so the adoption will proceed as quickly as possible in order to carry out the natural parent's intent.

In addition to an independent adoption, there are also adoptions in which the natural parent relinquishes all parental rights to an agency in order that the child may be adopted (C.C. 224m). Unlike the independent adoption situation there may be a period between the time parental rights are terminated and the time the adoption is completed, therefore, pursuant to Probate Code 1440.3, the director of the Department of Social Services (or the placing agency) is named as guardian of the child and the placement is supervised by the guardian or designee until the child is adopted. Moreover, if a guardianship petition has been filed by others, the state adoption agency informs the court of the pending adoption and requests a denial of the guardianship in order to expedite the adoption.

Although the department is not involved, in any manner, it should be noted there are other situations in which a governmental entity may become a guardian. In addition, County social workers are sometimes appointed representative payees for persons receiving SSI, although this is not a true guardianship.

Question 6A What progress has California made in establishing a Foster Care Information System?

Answer: California has three Foster Care statistical data collection systems in place. These systems work together to provide Foster Care information:

- Foster Care Registry
- AFDC - Boarding Homes and Institutions (BHI) Caseload Movement Expenditures Report,
- BHI Characteristics Survey

Foster Care Registry

The Foster Care Registry System provides characteristics and service data on all Foster Care Clients in California. No fiscal data is included in the Registry.

Due to system design flaws and an identified Department of Social Services need for additional Foster Care information, the Foster Care Information System is currently being redesigned. The redesign is scheduled for completion in December, 1979.

AFDC - Boarding Homes and Institutions Caseload Movement and Expenditures Report

This report provides summarized county and statewide payment and caseload data on all Foster Care clients who receive Aid to Families with Dependent Children - Boarding Homes and Institutions payments. AFDC-BHI Foster Care clients constitute about 96% of all eligible Foster Care clients.

AFDC-BHI Characteristics Survey

The AFDC-BHI Characteristics Survey provides valid statewide sample data on the characteristics, services, and fiscal payments received by eligible AFDC-BHI Foster Care recipients.

Question 6B How does the data collection system on services compare to your data collection on the fiscal side?

Answer: The services and fiscal information collected in the various statistical reporting systems described above are not comparable. To the extent possible, the systems have been designed to be compatible. Fiscal information from one system can be integrated with services from another. The majority of the information collected in the statistical reporting systems pertains to the characteristics and financial situation of children in Foster Care who receive AFDC-BHI payments. The major thrust of data collection efforts now underway including the revisions to the Foster Care Registry, is to up-grade the quality and amount of data on social services.

III. Articles and Resource Materials

LEGAL SERVICES FOR CHILDREN AND YOUTH
AN UNMET NEED

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INTRODUCTION

This paper is concerned with the need of American children and youth, particularly those from poor and minority families, to receive specialized legal advocacy services.* This need is not being met and cannot adequately be met by general service defender and legal aid or legal services offices. It is the thesis of this paper, however, that advocacy services for children and youth can be delivered at a reasonable cost if help is made available to interested lawyers and lay advocates to organize programs in their own communities.

In part I, this paper outlines the history of our changing attitudes toward children and youth as reflected in the legal and educational systems, and discusses the increasing alienation of adolescents as they experience conflict with the adult world. Part II of the paper describes typical legal problems faced by children and youth and discusses the advocacy needs which these and other problems regularly create. Part II is an analysis of the extent to which the existing system of defender and legal aid and legal services offices fails to meet the needs of children and youth. Finally, Part IV describes steps which can and should be taken for the development of specialized advocacy services for young persons.

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* Legal advocacy, as used in this paper, means advocacy (whether or not performed by lawyers) which addresses the legal problems of individual children and youth. Legal advocacy as thus defined includes consultation, negotiation, and representation of minors in court and before administrative tribunals such as school boards or their delegate disciplinary committees, welfare department hearing officers and the like. It does not necessarily include generalized advocacy for children and youth of the kind done by child welfare organizations, parent-teacher associations, and organizations for physically or mentally handicapped children. It does include referral of children and youth to non-legal service providers, preparation of plans for such services to be advocated in juvenile courts, and follow-up services to ensure that service providers meet their legal obligations to referred clients.

I. The Legal Status of Children in the United States

The contemporary legal status of children and youth is best understood in historical context. In the colonial era, children along with servants were generally treated as property. Children were virtually indentured to their parents, who had a right to their wages and to whom they owed the strictest obedience and subservience.[1] Disobedience was severely punished under the Massachusetts Stubborn Child Law of 1654.[2] Children were subject to the will of their parents (or their masters) until age 21.[3] However, as industry moved from the home and local craftsmen moved to the factory, children began to leave home, and judicial emancipation was occasionally decreed in order to terminate the parent's right to a child's wages where the parent had stopped supporting the child.[4]

1/ Katz, Schroeder and Sidman, Emancipating Our Children-Coming of Legal Age in America, VII Family Law Quarterly 211 (1973), reprinted in Katz, The Youngest Minority Vol. 1, p. 287 (American Bar Association, Section of Family Law 1974). Hereafter cited "Katz."

2/ Katz 212.

3/ Marks, Detours on the Road to Maturity - A View of the Legal Conception of Growing Up and Letting Go, 34 Law and Contemporary Problems No. 3, p. 78 (1975), hereafter cited "Marks."

4/ Katz 212.

By the early nineteenth century, most of the laws prohibiting children from living apart from parents were repealed or ignored. In the early years of the industrial revolution, children as young as eight years old were working in factories and living in dormitories or in boarding houses. In 1830, De Toqueville wrote that in America there was no adolescence; the male child went from boyhood directly to manhood in a natural and acceptable process. There was little or none of the domestic trauma which accompanies early parent-child separation in contemporary society. Even though the age of majority remained at 21, the doctrine of emancipation emerged in this period as the natural trade-off of the parent's support obligation for the minor's right to his own wages. Emancipation was approved when the minor left home, even without parental consent, and although the "stubborn child" statutes remained on the books they were not used to force runaways to return home or be incarcerated.[5]

During the nineteenth century there developed an almost total reversal of these colonial and post-revolution attitudes toward children. One major cause of change was the wave of immigration from Roman Catholic countries and the enormous growth of cities caused by the arrival of immigrant families with large numbers of children. The reaction of the Protestant settlers, while gilded with sympathetic rhetoric, was anything but benign from the point of view of the immigrant children. One early report, concerning New York City children, described their "ragged and uncleanly appearance," their "vile language," and their "idle.and miserable habits."[6] Such children were perceived as "pre-delinquent", and the doctrine of parens patriae was invoked to save them from the inevitable degradation of urban life by removing them to houses of refuge and rural institutions. The statutes enacted at this time made little distinction between criminal acts, neglect, and just plain vagrancy. State intervention was based on the status of the child: idleness and lack of adult supervision were sufficient to trigger the institutionalization of the urban child. Thus were born the "status offender" laws, which led in the last year of the century to the creation in Chicago of the first "juvenile court", a special forum with broad discretion to enforce the state's parens patriae power over unsupervised children.[7]

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[5] Marks 11-85.

The second major cause of these changes was the rather more sympathetic reaction to the horrors of the industrial revolution's child labor practices. This reaction found legal expression in the child labor laws and compulsory

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6/ 1823 Report by the Society for the Prevention of Pauperism in the City of New York, quoted in Fox, Juvenile Justice Reform: An Historical Perspective, 22 Stan. L. Rev. 1187, (1970).

7/ Fox, supra, passim.

education laws enacted by many states in the 1870-1920 period.[8]

The new attitude towards youth reflected in the status offender, child labor, and compulsory education laws was completely different from the colonial and post-revolutionary attitude. The child was no longer seen as a valuable source of labor, whose early transition to the adult world of work was to be encouraged. Instead, the child was to be nurtured and educated for as long as it was economically possible, and far beyond the ages of physical and cognitive dependency.

Through the first half of the twentieth century, the new attitude was solidified. The one room schoolhouse disappeared, to be replaced by schools in which children were eventually segregated into grades consisting entirely of children of the same age. The percentage of children attending full time school increased dramatically, with college and graduate school attendance increasing also. Simultaneously, job opportunities for young people decreased as machines replaced unskilled labor and family businesses failed or were absorbed into large corporations. No longer was it considered admirable for teenagers to leave school and home to go to work. Where parents objected (and often where they acquiesced), such conduct was punished under the status offender laws enforced by the juvenile courts. Such children then found their nuclear families and neighborhood schools replaced by

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8/ See Youth: Transition to Adulthood - Report of the President's Science Advisory Committee, 24-29 (Government Printing Office 1973). Hereafter cited "Youth Report."

institutional surrogates.[9]

By the middle of the twentieth century, the social and economic premises for the youth laws began to come under attack. While the exploitation of child labor had been eliminated, at least outside the agricultural industry, the great hopes of the nineteenth century reformers had not been realized. The long nurturing and schooling process brought middle class or professional status to only a small percentage of the children who endured the process. The nuclear family, cornerstone of American society, began to disintegrate. For children who did not conform or for those whose parents failed, the institutional surrogates proved disastrous in many cases--the promise of home-like care and rehabilitative treatment was not realized in the foster care and juvenile correctional systems. Unpleasant as were these alternatives to the nuclear family, they did not deter parents from divorcing or neglecting their children, and they did not deter increasing numbers of children from leaving school, running away from home, or engaging in criminal conduct.

Ironically, these developments occurred despite an unprecedented level of economic well being among children of families above the poverty level. With strong commercial encouragement via radio and television, a "youth culture" developed, entirely separate from, disrespectful of, and often antagonistic to the adult culture.[10] By segregating children

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9/ Marks 85-88.

10/ Youth Report 80-84, 112-125.

from the adult world with the best of intentions, our society made them a group of alienated outsiders. Saddest of all perhaps is the impact on *their* children, so often unwanted, neglected or even physically abused.

The legal system is slowly responding to the injustices of the nineteenth century youth law system. Procedural fairness for children in juvenile courts began to be enacted into the statutory law of many states even before it was constitutionally mandated by the U.S. Supreme Court in 1967.[11] In that same year, the failures of the juvenile justice and correctional systems were chronicled by the President's Commission on Law Enforcement and Administration of Justice.[12] Impelled by the disproportionate impact of the Vietnam War on youth, the states quickly ratified the 26th Amendment in 1971 reducing the federal voting age to 18, and most states reduced the age of majority to 18 in the few years which followed. The Juvenile Justice and Delinquency Prevention Act of 1974 provided funding to help runaway children outside the juvenile justice system, and conditioned federal delinquency prevention assistance to states on their willingness to stop treating status offenders like criminals.[13] Other recent federal laws have conditioned financial aid to states on the availability of adequate school feeding programs, medical screening, and special education services. Today, federal legislation is pending to reform the foster care system, and juvenile justice reformers in the states are urging repeal of the status offender laws, liberalization of compulsory education requirements, removal of youth employment barriers and emancipation of youth who demonstrate maturity.[14] Finally, the need to reform the antiquated laws defining the rights of children and youth has been recognized by public and private funding sources, which have given their support to reform-oriented legal programs such as the Youth Law Center, National Juvenile Law Center, Children's Defense Fund, and Center for Law and Education, all of which came into existence within the past ten years.

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[11] *In Re Gault*, 387 U.S. 1 (1967).

[12] See the President's Commission on Law Enforcement and Administration of Justice, *The Challenge of Crime in a Free Society*, and *Task Force Report, Juvenile Delinquency and Youth Crime* (Government Printing Office, 1967).

Despite the existence of a movement for law reform, however, the social and economic conditions which have caused our society to neglect and alienate its younger citizens will patently continue for the foreseeable future. These conditions are creating, and will continue to create, a multitude of legal problems for children and youth and for the majority of their

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13/ Juvenile Justice and Delinquency Prevention Act of 1974, P.L. 93-415, 42 U.S.C. Secs. 5601 et seq.

14/ See Standards for Juvenile Justice: A Summary and Evaluation (Institute of Judicial Administration-American Bar Association 1977).

parents who wish to help and support them.[15]

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[15] Notwithstanding the media (e.g. "Children Suing Their Elders in Burgeoning Rights Movement", headline in *Washington Post*, February 26, 1978, pp.1, 12; "Lawyers Who Protect Kids From Their Parents", headline in *San Francisco Examiner*, August 11, 1977, p.28), the vast majority of clients seen by children's lawyers are represented with the cooperation or at least acquiescence of their parents. In the author's experience, only two or three percent of the cases involved an outright conflict between client and parent. In most cases, the conflict is with a unit of state or local government purporting to act as surrogate parent under the *parens patriae* doctrine. Despite a recent spate of articles such as *A Bill of Rights for Children*, VI Family Law Quarterly 343 (1972), reprinted in Katz, *supra*, at 318, there is nothing new about declarations of children's rights. See, for example, *The Children's Charter* adopted by the 1930 White House Conference on Child Health and Protection, quoted in Katz, *supra*, at 32-34, or the United Nations *Declaration of the Rights of the Child* adopted unanimously by the General Assembly in 1959.

II. The Need of Children and Youth for Advocates

As was described in Part I, American youth are segregated from other age groups and are locked in a condition of dependency which extends far beyond the age of physical and cognitive maturity. These restraints place significant numbers of adolescent youth in a position of conflict with those who are in legal authority--parents, schools, juvenile court officials and others. For younger children, the problem is equally serious. Not only has the extended family almost completely disappeared in this society, but the nuclear family often includes only one isolated parent; when that parent encounters difficulty in providing adequate child-care, the younger child often becomes enmeshed in a bureaucratic tangle of official child-care agencies, with no effective advocate or representative. These are conditions which produce a growing need for advocacy.

There are approximately 70 million persons in the United States under the age of 18--about 32% of the total population. Of these persons almost 17 million are youth aged 14 through 17; at least 2.5 million of these youth are non-white.

Within the 0-17 year old group, almost 8 million children are AFDC recipients. However, because the total number of persons living below poverty income levels is over twice the number of AFDC recipients, the actual number of children in poverty families may be more than 15 million.

Representative Legal Problems of Youth

(1) Juveniles in Detention

In 1975, almost 1.7 million juveniles were arrested and taken into the custody of law enforcement officers.[16] Although placement into custody presents the most classic situation of needing the services and advice of a lawyer, the juvenile justice system ordinarily does not provide lawyers under such circumstances. The Supreme Court's Gault decision, which is narrowly interpreted in many states, requires that juvenile courts provide appointed counsel to children at all stages of proceedings in which conduct criminal for adults is being charged.[17] But many juvenile courts provide counsel only shortly before the adjudication hearing itself, and juveniles who are being held in detention awaiting those hearings usually have no access to appointed counsel during the critical early stages when officials are making decisions regarding whether to file charges, what charges to file, and whether to detain the juvenile pending trial (juveniles generally have no right to be released on bail). Very often juveniles are subtly pressured into

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16/ 1976 FBI Uniform Crime Reports.

17/ "We conclude that the Due Process clause of the Fourteenth Amendment requires that in respect of proceedings to determine delinquency which may result in commitment to an institution in which the juvenile's freedom is curtailed, the child and his parents must be notified of the child's right to be represented by counsel retained by them, or if they are unable to afford counsel that counsel will be appointed to represent the child." In re Gault, 387 U.S. at 41. Emphasis added.

making an "intelligent waiver" of the right to counsel at the early stages of a delinquency proceeding,[18] and in many cases even at the trial itself. Moreover, once the trial is over, and the disposition has been decided, there is no further right to appointed counsel in most jurisdictions, even if the juvenile is being incarcerated.[19] Each year, juvenile courts confine as many as 85,000 adjudicated juveniles in public custodial institutions where many of them remain for as long as several years.[20]

18/ Although the appellate courts in California held as early as 1966 that children had a right to counsel at preliminary detention hearings held shortly after arrest, In re Macedon, 240 Cal.App.2d 600, more than 90 percent of the children appearing at detention hearings in San Francisco in early 1970 were "waiving" their right to counsel at detention hearings. Affidavit of public defender on file in Scott v. Mayer, No. C-70-441, N.D. Calif. The federal judge found "...without the slightest question that there is a serious and substantial failure by the State of California...to provide adequate legal assistance to the Juvenile Court..." Id., Order dated April 13, 1970.

19/ Appointed counsel is not always available even to appeal from a delinquency adjudication, and is usually not available for collateral attack on an adjudication by, for instance, habeas corpus. There is no federal constitutional right to appointed counsel in probation or parole revocation hearings, Gagnon v. Scarpelli, 411 U.S. 778 (1973), except where state authorities deem that counsel is needed. Counsel at public expense is almost never available for the kinds of civil problems which juvenile prisoners have.

20/ Children in Custody--A Report on the Juvenile Detention and Correctional Facility Census of 1973, Table 6 (National Criminal Justice Information and Statistics Service, Law Enforcement Assistance Administration, December 1977).

Accused and adjudicated delinquents are not the only children incarcerated by the juvenile justice system. The system also detains status offenders (children who commit non-criminal acts such as truancy, running away, or disobedience to parents). On an average day in 1975, there were 8,810 status offenders in American custodial institutions.[21] Status offenders , who are treated like criminal delinquents in most states, have even less access to legal services because many jurisdictions provide no appointed counsel at all in cases of non-criminal misbehavior. Surprisingly, juvenile detention and correctional institutions also housed 5,295 neglected children in the 1975 census; these were children officially classified purely as victims rather than as misbehavors.[22]

It should be noted that the above statistics can be misleading in two respects. First, the figures deal only with "juvenile" facilities. On any given day, there are close to 8,000 additional children held in adult jails, mainly in rural areas with no separate juvenile facilities. Secondly, the daily population figures are much lower than the annual numbers of children who are incarcerated; if short-term detention is included in the calculation, it is estimated that

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21/ Children in Custody-Advance Report on the Juvenile Detention and Correctional Facility Census of 1975, Tables 9 and 11 (National Criminal Justice Information and Statistics Service, Law Enforcement Assistance Administration, October 1977).

22/ Id.

23/ The Detention and Jailing of Juveniles: Hearings Before the Subcommittee to Investigate Juvenile Delinquency of the Committee on the Judiciary, U. S. Senate, 93rd Cong., 1st Sess. 4 (1973) (statement of Sen. Birch Bayh).

almost 500,000 children enter juvenile facilities every year, and that over 100,000 additional children are jailed in adult facilities every year.[24] Of all these young persons, the only ones who are guaranteed appointed counsel are those who stand trial on criminal delinquency charges, and then only for the purposes of the trial itself and only if they do not "intelligently waive" the right to counsel.

In addition to the need of incarcerated children for legal assistance regarding their juvenile court proceedings, such children typically have other legal problems, as demonstrated in a recent one-year experiment undertaken at the University of Minnesota. Of between 450 and 500 potential clients incarcerated in Minnesota juvenile facilities, 217 children brought 307 different legal problems to a legal services program which was set up to offer civil legal assistance to juvenile inmates. Three quarters of these problems related to situations other than the police, the juvenile court, or the facility where the client was held.[25] One conclusion from this experience was that "(n)o group of consumers are more in need of advocates and counsel than young people who are the wards as well as the responsibilities of the State."[26]

24/ Id.

25/ Clendenen, Cullen, and Goldberg, Legal Assistance to Delinquents. 41 Federal Probation No. 3, p. 8 (Sept. 1977).

26/ Id. at 14.

(2) Children of Divorce

In 1976, there were 1,079,000 divorces in the United States, more than double the number in 1966. Almost one-half of all marriages now end in divorce.[27] While no statistics are available regarding the number of children involved in divorces, the number is obviously enormous.[28] The trauma and anxiety suffered by children of divorcing parents is well documented. Nonetheless, children traditionally were not considered parties to divorce actions and thus were accorded no voice in decisions regarding custody and visitation.[29] Today, the trend is toward granting them party status in the proceedings, with a right to counsel, if they are mature enough to articulate a preference regarding custody and visitation and if they can afford or otherwise find counsel to represent them. Independent counsel for the child can be extremely important in divorce actions because there is often a conflict of interest between the child and both parents. For example, child custody and visitation issues are often bargaining points related to the amount of child and spousal support to be paid by one party to the other.

27/ Division of Vital Statistics, U.S. Department of Health, Education and Welfare. 1978 World Almanac, p. 951.

28/ For example, 56 percent of married men aged 20 or 21 have children, and 68 percent of married women in that same age group have children. Where the parents are 22, 23, or 24 years old, the percentages rise to 69 percent for the men and 78 percent for the women. Youth Report, supra, page 56.

29/ deMontigny v. deMontigny, 233 N.W. 2d 463 (Supreme Ct. of Wisconsin 1975); Goldsmith v. Jekanowski, No. 75-1308F (footnote cont'd)

(3) Runaways

In 1974, 239,600 children were arrested for running away from home; however, the total number of run-aways is estimated at one million each and every year.[30] While arrested runaways may qualify for defender services in juvenile court, runaways who are not apprehended are not so served. Among non-public defender law offices that presently provide free legal aid to youth, one of the largest categories of requests for legal services is from runaways who need help and have no other confidential source of information and advice. Most runaways leave home because they simply cannot get along with their parents, but the next largest category leave home because of physical abuse by their parents.[31] Moreover, three-quarters of all runaways have never committed any crime.[32]

Legal assistance for runaways is particularly important for several reasons: (1) as there is no uniformity among state laws regarding status offenders, most runaways do not know

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(footnote 29 cont'd)
(D. Mass.1975). The most influential recent work on children's rights recommends that they be accorded party status. Goldstein, Freud and Solnit, *Beyond the Best Interests of the Child*, page 65 (MacMillan 1973). A number of states, including Arizona, California, Colorado, Connecticut, Kentucky, and Washington, have amended their divorce laws in recent years to allow children to appear with attorneys in appropriate cases.

30/ Hearings Before the Subcommittee to Investigate Juvenile Delinquency of the Committee on the Judiciary, U.S. Senate April 29, 1975, p. 523.

31/ *National Statistical Survey of Runaway Youth*, Table 38 (Opinion Research Corporation 1976).

32/ *Id.*, Table 31.

what will happen to them if they seek help from official or semi-official agencies; (2) legal services are the only services known to youth to be confidential; (3) unless the runaway goes home, he or she is, in effect, an "outlaw" and cannot legitimate his or her status without legal assistance.

(4) Abused and Neglected Children

In many states, juvenile and family courts are not required to appoint independent counsel for abused and neglected children.[33] Thus, as in divorce proceedings, the person most affected by the court's decision has no direct representation. On the one hand, most cases of abuse and neglect go undetected;[34] On the other hand, those that are reported result too often in consigning the child to the "limbo" of the foster care system which now houses 350,000 children nationwide. Incredibly, about one-third of the children who are placed in foster care are literally "lost" in a system which includes few incentives either to return them to their parents or to free them for adoption.[35] Independent counsel for the child could often prevent this result by advocating in-home services to protect

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33/ Katz, et al., Child Neglect Laws in America, IX Family Law Quarterly No. 1, pp. 1, 32-33 (Spring 1975). While the summary (pp. 32-33) states that there is a right to appointed counsel for allegedly neglected children in 27 out of 54 jurisdictions, the specific language of the statutes indicates that the "right" is actually discretionary with the court in 4 out of those 27 jurisdictions.

34/ The number of cases of physical or sexual abuse and severe neglect has been estimated at 665,000 per year, with the researcher estimating that the number may be as high as 1,675,000. Light, Abused and Neglected children in America, 43 Harvard Education Review 556, 567 (1973).

35/ Statement of Congressman George Miller in support of H.R. 7200, quoted in Los Angeles Daily Journal for March 2, 1977, page 1.

the child while at the same time avoiding family break-up. With older children, counsel can be useful in advocating the child's own preference or can help the child who has been placed in a harmful foster home or institution. Additionally, children who are being physically or sexually abused can receive legal help without automatically triggering the child abuse reporting laws because of the confidentiality of the attorney-client relationship.[36] This is important because most children do not wish to have an abusing parent or step-parent exposed to criminal penalties and therefore do not wish to have the abuse reported to police, doctors, or social workers.

(5) School Suspensions, Expulsions, and Involuntary Transfers

One of the commonest problems a children's lawyer faces is school disciplinary proceedings. A study of Boston secondary schools in 1973-74 revealed that 9.2% of all students were suspended.[37] If that rate were applied to the 14,321,000[38] students who enrolled in secondary schools in the United States

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36/ For example, a typical child-abuse reporting act requires that child abuse be reported to the police by all of the following kinds of persons, but *not* by lawyers: physicians, surgeons, dentists, residents, interns, podiatrists, chiropractors, marriage, child or family counsellors, psychologists, religious practitioners, registered nurses, school superintendents, truant officers, principals, teachers, licensed day care workers, camp administrators, social workers, peace officers, and probation officers. Calif. Penal Code, §11161.5. It is a crime for any such listed person having knowledge of child abuse to fail to report it. *Id.*, §11162.

37/ Miller, *Student Suspensions in Boston*, 20 Inequality in Education 16, 17 (July, 1975).

38/ Office of Education, Department of Health, Education and Welfare. *World Almanac*, p. 180.

in the fall of 1976, there could be as many as 1.3 million school suspensions nationwide each year. In such proceedings, an advocate is needed not only to ensure that the charges against the student have a factual basis, and to present facts in mitigation, but to ensure that the suspension does not exceed statutory limits, to obtain alternative educational services for the child during the period of suspension, and to explore possible long term alternative education programs for the child whose problems may require a change in school environment. Effective advocacy at this point is crucial, as many older children will drop out of school permanently if they are given a lengthy suspension or if they are transferred involuntarily to a different school for disciplinary reasons.

(6) The Handicapped Child

About 45,000 minors are admitted annually to psychiatric institutions.[39] Many more have been placed in institutions for the retarded or for the multiply handicapped. Conditions in many of these institutions have been condemned as "disgraceful and intolerable."[40] Although most civil commitment statutes require hearings, with right to counsel, for persons involuntarily committed, children "voluntarily" admitted by their parents until recently had no right to a hearing or to a lawyer. The Supreme Court is currently considering whether

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39/ National Institute of Mental Health, Statistical Note 90, Utilization of Psychiatric Facilities by Persons Under 18 years of Age. Table 1 (1971).

40/ Joint Commission on the Mental Health of Children, Crisis in Child Mental Health Care 5, 269 (1969).

the Constitution demands such protections,[41] and the California Supreme Court ruled last year that minors over 14 who are "voluntarily" admitted by their parents are entitled to a hearing with counsel.[42]

Under the Education of all Handicapped Children Act, P.L. 94-142, which has recently become effective nationwide, every public school must provide special education where indicated for children who are retarded, hard of hearing, visually handicapped, seriously emotionally disturbed, or otherwise impaired. The comprehensive provisions of this Act will probably take years to be fully implemented, and advocates will be needed to assist children and parents under the grievance, administrative hearing, and judicial review provisions.[43]

(7) Miscellaneous

There are many other situations in which children and youth need advocacy services, but which will not generate sufficient financial recovery to sustain a private attorney. Some actual examples: An emancipated minor, 2,000 miles from the home of her parents, requires medical care, but her parents will not sign a consent for her to obtain Medicaid assistance; a woman dies, having set up a bank account "in trust for" her granddaughter, but the bank allows the step-grandfather to withdraw the $2,500 in the account; a public housing authority evicts a narcotics addict for failure to pay rent, confiscating and selling both her property and the property of her orphaned nephew who was living with her; the adult sister of another orphan kicks her out of her house, but refuses to consent to a petition by a responsible adult to become the girl's legal guardian; an emotionally disturbed ten year old boy, mislabelled "developmentally disabled," is removed by the social services department from a long-term foster home simply because the home does not have a special license for retarded children, yet when the boy is retested he is found to have an I.Q. well above normal.[44]

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[41] Parham v. J.L., No. 75-1690, probable jurisdiction noted, May 31, 1977.

[42] In re Roger S., 19 Cal.3d 921 (1977).

[43] P.L. 94-142, 20 U.S.C. §§1401,1415.

44/ All of these examples are actual cases in which the juveniles in question did receive legal assistance from Legal Services for Children in San Francisco.

III. The Advocacy Needs of Children and Youth Are Not Being Met

Almost all minors are "poor persons" in the context of legal services, since they themselves have no financial ability to hire a private attorney. As previously noted,[45] there is relatively little litigation directly between children parents; but there is much conflict between them and it is the rare middle-class parent who will pay for the services of a private attorney for consultation with his or her child on a confidential basis or foot the bill for defense of a runaway charge which was intitiated by the parent himself. The problem is recognized in the juvenile court laws of some states which provide defender services to all children in delinquency cases without regard to the parent's ability to afford private counsel.[46]

On the other hand, middle-class parents can and do purchase medical, psychiatric, and educational services for their children, who are therefore less likely than poor children to need advocates to obtain services from public health and welfare agencies. For these reasons, this part of the paper concentrates on the availability of legal services to children of the poor.

There are two systems of legal assistance for poor persons in the United States: defender services for criminal and juvenile delinquency cases funded by state and local govern-

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45/ Note 16, *supra*.

46/ For instance, California Welfare and Institutions Code, Section 634.

ments, and legal services offices[47] for civil legal problems funded primarily by the Legal Services Corporation.[48]

Defender services are provided either by full time public defender offices or by panels of private attorneys appointed and paid by the court on a case-by-case basis. Under the Supreme Court's 1967 Gault decision, minors accused of crime are entitled to defender services. But many states do not provide defender services to status offenders even though they may be institutionalized for their noncriminal behavior. In a recent survey of 29 runaway shelters serving runaway youth in 22 states, 66 percent of the agencies reported that of their runaway clients who were processed in juvenile courts, the percent who were not represented by lawyers varied from 15 to 99 percent, and averaged 64 percent. Eight of the 29 respondents, or one-fourth of the total, reported

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47/ Some civil case services are provided by "Legal Aid" offices. The name connotes an older office which was in existence before the advent of federal legal services funding in the mid-1960s. Legal aid services were typically provided by volunteer lawyers with staff support funded by local charities or a bar association. There are still a significant number of legal aid offices which are locally funded and do not receive assistance from the Legal Services Corporation. See note 38, infra.

48/ The Legal Services Corporation is funded by Congressional appropriation and is governed by a board of directors appointed by the President and confirmed by the Senate. The Corporation is the successor to government legal services funding programs under the Office of Economic Opportunity and Community Services Administration.

that there was no source of free legal assistance for their status offender clients.[49]

The Legal Services Corporation permits legal services offices to represent children in juvenile court, but no Legal Services Corporation funds are specifically allocated for the direct representation of children; legal services offices set their own priorities. Forty-five percent of the respondents in the above survey reported that their local legal services offices either refused to represent children or gave children's cases a low priority. One such program, which is now hiring its own in-house lawyer, described the situation as follows: "Lawyers unfamiliar with legal procedures and court strategies. Insensitive to youths' problems, needs and feelings." One large legal services program, with twelve offices and a national reputation for quality work, has announced in its brochure that it "cannot help you with...juvenile cases...including juvenile juvenile traffic offenses, removal of juveniles from home, and out of control or runaway juveniles." On February 1, 1978, a listing of 135 attorney positions in legal services offices listed 108 of those positions as being for specialized problems or client groups. "Juvenile" was listed once, as was "Education."

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[49] Survey conducted in February, 1978 by the National Child and Youth Advocacy Development Project. Results listed are partial. The agencies which reported that there were no free legal services available for status offenders are located in Hawaii, Nevada, Iowa, Mississippi, Missouri, Pennsylvania, Florida, and Maryland.

On the other hand, "Elderly" was listed 8 times; "Native American" 5 times, "Hispanic" 10 times, and "Migrant" 11 times.[50]

In the above-mentioned survey of runaway programs, 27 out of 29 reported that their clients had legal problems in addition to juvenile court matters. Problems listed included tort defense, parents disputing custody, welfare or health benefits being withheld, school expulsion or suspension proceedings, commitment to mental hospitals, adoption or guardianship proceedings, commitment to mental hospitals, adoption or guardianship problems, physical or sexual abuse by parents, and emancipation proceedings.

The lack of legal assistance for youth reflects not so much that legal services lawyers are insensitive to the needs of children, as that legal services lawyers respond to the articulated demands and needs of poor persons in their communities. Children, almost by definition, are a disenfranchised and inarticulate minority. They cannot, and do not, join in the competition for the limited services of legal services offices; their voices are not heard among the demands of tenants, consumers, the elderly, the welfare recipients, and the ethnic minorities.

50/ Position Vacancy Bulletin, February 1, 1978 (Legal Services Corporation.

IV. Specialized Advocacy Programs for Children and Youth

Because they cannot compete for general legal services, the advocacy needs of children and youth must be met by specialized programs. In the runaway program survey described earlier, most of the programs which reported having access to adequate legal services also reported that such services were rendered either by an in-house specialist lawyer or by a program specializing in representing children and youth. In fact a few specialized advocacy programs have been developed around the country, including Legal Services for Children in San Francisco and the Juvenile Law Center of Philadelphia, as well as law student clinical programs at law schools in Los Angeles, Baltimore, and Nashville.

Interest and enthusiasm about developing new programs are high. In 1977, the Youth Law Center and Legal Services for Children in San Francisco received letters from persons and organizations in more than 85 cities asking for information and assistance in setting up programs of legal assistance for children and youth.

What is needed, therefore, is a national initiative to foster the development of legal services for young people. An effort must be undertaken to respond to the requests of those organizations and individuals that are moving to develop programs in their communities, and to stimulate even broader interest and activities on the local level. At the same time, information should be collected identifying all existing funding sources, and this information should be shared with all interested persons and programs.

A clearinghouse should be established for the purpose of gathering information and giving assistnace in program development. An assessment of the few existing programs should be made so as to determine what models are most effective for the delivery of legal advocacy services.

A major goal of this effort must be to obtain recognition by local, state, and federal governments that legal advocacy for children and youth is a necessary social service which should be mandated in governmental children's service programs. One possible strategy to acomplish this might be through the legislation of a "Younger Americans Act" similar in format to the Older Americans Act first passed in 1965. (An initial draft of such legislation has been formulated by the Youth Development Bureau of the Department of Health, Education, and Welfare. Moreover, conversations with staff of Congressional sub-committees indicates that there is considerable interest in such legislation.) Children and youth are in a parallel state to the elderly regarding the multiplicity of complex laws and administrative regulations to which they are subject, and in their very limited access to legal representation and advocacy. In 1975, the Older Americans Act was amended to identify legal advocacy for the elderly as a critically needed service which should be targeted for special emphasis.

Governmental administrative agencies must also be persuaded to develop intiatives in this area, and other sources--public and private--must be tapped. LEAA, VISTA, CETA, HEW, HUD; foundatons, United Way; schools of law and social work--all are potentially available for support.

Enormous amounts of money are currently being expended in programs designed to benefit American children and youth. The sum total now spent for education, nutrition, health care, welfare and social services, mental health, drug treatment, delinquency prevention and corrections is staggering. Yet the problems facing young people continue to multiply, while the efficacy of many programs is increasingly called into question.

Many of those who are concerned have entered into debate about what the causes are of the multiplicity of youth problems; how to "cure" individuals; how to re-reorganize the system of services. It may be that this debate will never end. While it continues, more effective means must be found, now, to shake resources out of this mega-system for the individual young person--and to make those resources work. Legal advocacy programs can accomplish this; without such programs, young people are powerless to make the system work for them.

The high level of interest in legal advocacy programs around the country, as well as efforts in a number of communities to develop programs, indicate that sufficient energy exists on the local level to provide such services. What is essential at this time is an effort to provide focus for this energy, and to ensure that the resources necessary to coherent program development are made available. Attention must be drawn, on the state and national levels, to the need for legal advocacy services for children and youth. For example, the HEW draft "Younger Americans Act" does not presently include specific reference to legal services.

In summary, if the need for services identified in this paper is going to be met, it is essential that, at a minimum, the following tasks be accomplished:

1) The stimulation of legislative action and administrative initiatives to provide the resources necessary for coherent program development.

2) The provision of direct technical assistance and support to local efforts to establish legal advocacy programs for children and youth; and

3) The establishment of a clearinghouse for information on program development and funding resources.

It is the purpose of this paper, therefore, not only to identify and focus attention on children and youth for legal services, but to stimulate action to address that need. The National Child and Youth Advocacy Development Project was created to engage in such action, and is prepared to assist others in doing so. Inquiries and comments should be sent to:

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National Center for Youth Law
693 Mission Street, Sixth Floor
San Francisco, CA 94105

Tel: (415) 543-3307

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THE NEW YORK TIMES, WEDNESDAY, DECEMBER 20, 1978

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State Tries to Get Child Facility To Limit Physical Punishments

By RICHARD J. MEISLIN

Dr. Matthew Israel, whose child-care institute in Providence, R.I., was ordered by New York State to stop using physical punishment on the mentally disturbed and retarded New York children it cares for, met with state officials in Albany yesterday in an attempt to agree on limits that would allow the program to continue.

Meanwhile, Los Angeles authorities reported that they were investigating allegations by a worker at Dr. Israel's smaller, parallel West Coast facility in Los Angeles that the institute had used methods that might have been illegal under the state's child-abuse laws. A spokesman for the Los Angeles District Attorney's office said the office expected to complete its investigation in January.

The negotiations between Dr. Israel and Louis Grumet, the state's assistant commissioner of education for handicapped children, were reported to be making progress, although no agreement had been reached late yesterday.

The meetings followed an agreement by Dr. Israel late Monday to suspend his threat to force the 15 New York children who are autistic, severely retarded and sometimes violent to leave his Behavioral Research Institute in Providence unless the state revoked its order.

Dr. Israel made that concession after meeting with parents of some of the children at the Rockland County Court House in New City, N.Y., where he received tentative assurances from state officials that they would give him the rate-increase he wanted if he brought his program into compliance with their regulations.

He has been asking for an increased rate of $38,000 a year a child, from the current $31,600. But the state has refused to grant it unless Dr. Israel hires properly certified staff members, improves some of his educational programs and stops using the physical punishments. In a draft report, issued to him Friday, the state gave him 60 days to do so.

Referring to the punishments, Ilene Margolin, executive director of the state Council on Children and Families, said, "The aversives have to be stopped. That is our bottom line."

She said the state was unwilling to accept any use of the punishments — which include bare-bottom spanking, bruising pinches and sprays of water in the children's faces — except in cases where the child is likely to do damage to himself or another person.

She said the state had a "contingency plan if we have to move the kids out of the program."

Dr. Israel's program of behavioral training is regarded as highly successful in controlling the behaviors of the retarded children, many of whom are self-abusive and dangerous to others.

But opponents argue that in many cases Dr. Israel could get the same results without the punishment. "I'm not condemning the use of punishment in general," said Dr. Irwin Mansdorf, one of the investigators who visited the facility. "The question is whether the ends justify the means." He said he objected to the use of physical punishments to eliminate even minor aberrations, such as rocking back and forth, without first trying less drastic or painful alternatives.

Federal Probation

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This Issue in Brief

Is Restitution Practical?—Several practical problems must be resolved before restitution can be systematically used as a criminal justice sanction, asserts Burt Galaway of the University of Minnesota School of Social Development. Issues occur in the areas of determining the amount of restitution, enforcing the restitution obligation, and the cost of the restitution sanction. Experience of existing pilot restitution projects indicates that these problems are resolvable, Galaway concludes.

Legal Assistance to Delinquents.—The LAD program of legal services to institutionalized juveniles who had been judicially separated from their families by reason of delinquency is described by Professors Clendenen, Cullen, and Goldberg of the University of Minnesota Law School. LAD aimed to upgrade the quality of justice for such youth through the provision of legal counsel and assistance. The program furnished some instruction on basic legal rights and responsibilities insofar as they relate to and govern relationships between authoritative correctional agencies and clientele.

Evaluation of Adult Diversion Programs: The California Experience.—For a 2-year period 16 community-based adult diversion programs were evaluated by the California Department of Corrections, reports Michael W. Agopian, the Department's evaluation coordinator. The programs concerned three categories: pretrial diversion, residential alternatives to incarceration, and alcohol and heroin detoxification. Throughout the research effort three characteristics of diversion operation affected program evaluation: variation of a client's degree of penetration into the justice system, abuse of client criminal information, and offense severity of clients influencing cost analysis.

Recent Changes in the Administration of Parole in France.—This article by law professor John P. Richert reviews developments in the administration of parole in France. Introduced in 1885, the French parole system changed little until the early 1970's. The legislative reforms of 1970 and 1972 eliminated some of the punitive aspects of parole and treated it as a tool for rehabilitation. Decisionmaking has become more decentralized

CONTENTS

Is Restitution Practical? . . . . *Burt Galaway* 3
Legal Assistance to Delinquents
Richard J. Clendenen
James P. Cullen
Melvin B. Goldberg 8
Evaluation of Adult Diversion Programs: The California Experience . *Michael W. Agopian* 15
Recent Changes in the Administration of Parole in France . . . . *John P. Richert* 19
Save Parole Supervision . . . *Robert Martinson*
Judith Wilks 23
The Imprisonment of Bank Robbers: The Issue of Deterrence . . . . *James F. Haran*
John M. Martin 27
Training for Criminal Justice Personnel: A Case Study . . . . *Gad J. Bensinger* 31
Faking It . . . . *Charles L. Erickson* 36
The Zero-Base Budget as a Management Tool
Joseph S. Coughlin
George F. Gruendel
Donald E. Shay 39
The Probation Rehabilitation and Employment Program . . . . *Henry R. Cellini*
John Giannini
Debra L. Wright
Don Coughlin 42

Departments:

Looking at the Law 47
Legislation 50
Letters to the Editor 51
News of the Future 53
New Careers 54
Reviews of Professional Periodicals 55
Your Bookshelf on Review 60
It Has Come to Our Attention 69

offenders are resolvable and guidelines are available to deal with the issues of payment for intangible damages, partial restitution, and excessive restitution. There does not appear to be any particular reason to believe the major problems will be encountered in enforcing the restitution obligation so long as installment payments are authorized; implementation of the restitution agreement is monitored; judicious use is made of job finding services, public employment, and personal service restitution; and a more severe sanction can be imposed if the offender refuses to complete the restitution obligation. If restitution can be used as an alternative to present correctional programs, the overall sanctioning costs will be reduced. Attention should be given to defining types of offenses for which restitution might be a sole penalty. Finally, the issue of victim culpability should not deter from the imposition of a restitution requirement; an offender's dignity is much more protected when he is treated as a responsible person who can be held accountable for choosing a criminal alternative even when confronted with a provocative situation.

The practical issues can be resolved on a case-by-case basis using a negotiation procedure by which the victim and offender work with a public official to arrive at a restitution agreement. Once developed, this agreement should be enforced as the major sanction against the offender. Such a program should reduce the need for large correctional bureaucracies and should be actively pursued as a means for dealing with specified types of offenses, especially property crimes.

Legal Assistance to Delinquents

BY RICHARD J. CLENDENEN, JAMES P. CULLEN, AND MELVIN B. GOLDBERG
University of Minnesota Law School, Minneapolis

ALTHOUGH juveniles enjoy certain legal protections in America which are not extended to adults, they also suffer numerous disadvantages and handicaps in their ability to assert and defend their own best interests as they perceive them. The adult who believes himself to be injured by another may bring suit to obtain relief or even damages. The juvenile must await his parent or guardian taking the initiative to institute a similar course of action for him. For the juvenile who has been removed from his own home, who is living with foster parents or staff of a child caring institution, resort to such relief becomes even less likely, particularly if he wishes relief from his custodians.

A part of the problem such youth face in asserting their own interests grows out of the attitude common to many institutions dealing with juveniles. Schools, juvenile courts, welfare agencies, and other agencies—police, correctional agencies—see themselves as the protectors of youth. Confident of their expertise and knowing that their aim is to help youth, it is difficult for these agencies or even the general public to recognize that failures to serve the juveniles' best interests do occur. As Morris and Hawkins point out in generalizing from the situation in Illinois:

> Nobody doubts the benevolence and good will behind the efforts of the juvenile courts and the state youth commissions. Nor is it possible to doubt the great power they wield over the lives of children and their families. What we should have doubts and also anxiety about are the problems which develop when these types of rescue operations become institutionalized. Too often what happens is that the rescue operations ignore the preferences of those who are to be rescued.[1]

This perspective of the position and plight of juveniles in the American institutional system provided the impetus for the development of Legal Assistance to Delinquents (LAD), a legal services program for youth separated from their families by court action and residing in some form of group care, i.e., group homes or institutions.

The program was undertaken by the University of Minnesota with the assistance of funding provided by the Governor's Commission on Crime Prevention and Control.

As an experimental program, LAD sought answers to a number of questions. Do juveniles living away from their families in some form of group care have significant need for legal assistance relating to civil problems? (The Minnesota Public Defender service is available to assist them in matters relating to their commitments.) If so, what legal problems of a *civil* nature do such juveniles have? Would juveniles recognize civil legal problems or problems of a civil nature for which legal assistance could be helpful? Assuming that they could be helped to recognize problems for which legal assistance would be appropriate, what would be required in the way of service delivery to reach them? Can a juvenile establish a valid lawyer-client contract of his own volition or must a parent or guardian give approval? Or since these youth had become wards of the juvenile court, must that agency give consent?

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[1] Norval Morris and Gordon Hawkins, *The Honest Politician's Guide to Crime Control.* Chicago: University of Chicago Press, 1970, pp. [illegible].

We were interested also in assessing the impact of the proposed legal services upon treatment programs and the response of youth to such treatment programs. Would group home and institutional administrators become more sensitive to the legal rights of juveniles, and would any increased sensitivity be reflected in changes in rules, regulations, or procedures? Would due process hearings, for example, be introduced into some of the decisionmaking procedures in matters affecting vital interests of juveniles? And would providing youth legal services increase their sense of significance and feelings of power and control over their experience? Would they be more likely to feel that the system is fair and honest because of services received from LAD?

Legal Status of the Juvenile

The tenuous legal status of a minor in this country makes the problems of incarcerated youth particularly unique. Presumably the minor living at home is under the care and protection of concerned parents. While previously the juvenile offender had at least some input into his life decisions simply because of his presence in the family and community, incarceration acts to sever these relationships. In its place is the institution or group home, often understaffed, responsible for his custody as well as care, and frequently resistive to any assertion by the youth that his input into the system should be considered. Thus the goals of a juvenile legal services program include not only the preservation of the individual's legal status in the community "outside" and protecting his established rights on the "inside," but perhaps more importantly, developing the reasonable rights of an incarcerated youth to have some say about his own destiny.

Development of the Project

A first task in organizing and structuring the project was to locate as exhaustively as possible the whereabouts of the juveniles we proposed to serve. Unlike the adult prison population, which is incarcerated in a few major institutions, juveniles are spread throughout Minnesota in a myriad of halfway houses, group homes, county institutions, state facilities, and foster home placements. The effectiveness of the projected manpower for the project, three attorneys, and one paralegal worker (not including two supervising faculty members) would have been wastefully dissipated by efforts to find ways to reach and serve all youth technically eligible for our services. As a result, LAD served only the easily identifiable juvenile facilities in the Twin Cities area, ranging in size from group homes housing 10 to 12 youths to two county training schools with yearly populations of approximately 650 youths. Smaller group homes were added primarily because they served as a funnel for youths previously incarcerated in the larger institutions, and LAD clients of necessity were followed from facility to facility. One nearby State facility for juveniles, Lino Lakes, received service but was in the process of conversion to an adult facility. Some service was given also at the State Training School at Red Wing (65 miles distant) as it began to receive metropolitan area youth phased out of Lino Lakes.

No attempt was made to provide services to youth committed to mental institutions or to other non-delinquent, but judicially placed children. These limitations reflected the lack of resources available to the LAD project, not a demonstrated lack of need for services. In fact, with the proposed decriminalization of certain status offenses, and possible resulting increases in use of mental hospital commitments for such behavior, there may be increasing need for adequate legal services for such youth.

Organization of the Project

Development of the LAD Project required finding answers to three basic questions. First, how do you identify clients who need the services that the project can provide? Secondly, what administrative arrangements and procedures will be needed with the institution or group home served in order to provide adequate services? Finally, what is the relationship of the project to the state and private agencies serving the same client?

The mechanics of locating clients for LAD within the populations served necessarily varied with each institution or other facility, but two basic requirements were common. Initially, potential clients had to be informed that the LAD Project existed and was available to them. Secondly, because of the turnover in the population of the institutions, such information had to be provided on a continuing basis. LAD used open meetings to initiate contacts within each institution. This included an orientation session for the staff prior to a general group meeting with the youth. Staff were encouraged to make referrals to LAD when they believed that youth had a civil legal problem. In addition, each institution was provided an explanatory poster and stamped, self-addressed LAD envelopes with request forms available. When possible, subsequent group meetings were held periodically by LAD staff to re-explain the program. Although LAD's phone number was available, most institutions serviced by the project restricted use of the phone by youth, a factor which may help explain why calls from LAD clients were rare.

Once client contact was initiated, the administrative and procedural arrangements which had been worked out with the institution became of crucial importance. Since interviewing necessarily was done within the institution rather than at LAD offices, the need for privacy and confidentiality for the client was essential. Through a variety of ways, the staff of the institution or group home could facilitate or interfere with the effective provision of project services. Once the role of LAD had been defined, the majority of institutional or group home personnel appeared comfortable in their contacts with LAD, referred youth to the program, and cooperated in making youth as readily accessible as possible to see and confer with LAD representatives. That this occurred in most cases is a compliment to both LAD and institutional personnel since some anxiety about the program was expressed initially in every setting used. "What will a lawyer do out here?" was a common query.

LAD attempted to establish immediately with each institution a policy for its interviews, the boundaries of attorney-client privileges, and due process procedures for inhouse disputes. These included such specific issues as private rooms for interviews, clarification of mail policy governing letters sent to and from attorneys, clarification of visiting and telephone privileges between attorney and client, and the role of the LAD attorney in representing youth charged with serious inhouse violations of prescribed rules.

Not all facilities or their staffs felt comfortable with the LAD project. Some staff feared that LAD would disrupt treatment plans by supporting any resistance a child might feel about undertaking some new program. Lacking organized grievance procedures, youth in some of the settings brought many complaints to LAD of staff actions. Some of these grew out of simple misunderstandings which LAD helped to clear away. Others alleged actions which appeared to represent physical abuse of the juvenile or significant violation of his legal rights. LAD inquiries into such matters created tensions among the staff involved as well as the administrative personnel responsible for the programs. LAD regularly took such complaints to the responsible administrators, and in the very large majority of cases they were cleared up without difficulty. When found to be valid, the disposition of a complaint might involve a staff-child conference to clarify a misunderstanding, an adjustment in a child's program, the modification of a rule or procedure, or occasionally a staff reprimand. Institutional personnel expressed appreciation on several occasions for LAD's intervention in bringing such problems to the attention of staff.

Frequently LAD attorneys were approached by staff in the various institutions about "their rights." Unless there was a conflict of interest, the LAD staff gave whatever help it could in clarifying such matters. LAD attorneys also wrote position papers on various inhouse issues at staff request, thus making input to institutional policy development. Help was given also through educating group home and institutional staff on legal principles through informal question and answer discussions with LAD staff which took place quite frequently.

Experience proved that the juveniles brought a wide array of concerns and problems to LAD—a total of 307 problems by 217 clients during the year. The exact number of youth served by these facilities, excluding Red Wing, during that period is not available, but between 450 and 500 would appear to be a reasonable estimate. In the aggregate, then, somewhat fewer than half the youth in these facilities sought help on some kind of problem from LAD, with percentages varying considerably from that average within individual facilities.

In terms of the kind or nature of problems brought to LAD, fully 25 percent of the problems, complaints, or questions related to the juveniles' legal situation vis a vis the police, the juvenile court, or the facility wherein he resided. The next largest number of questions or complaints centered upon institutional or group home procedures or care. Here the greatest number came out of one county institution, where a significant number of complaints were received alleging staff abuse. More issues were raised about the role or action of public welfare than any other one government agency. This seems logical since a large number of the youths were in the custody of welfare agencies. Many of the domestic problems presented reflected the child's dependent position in his or her family. Several youth were questioning the right of parents to make certain demands or impose certain limitations upon them.

Did LAD Make a Difference?

Behind the above statistics are young people with problems ranging from the insignificant to those which have implications for their entire future lives. Sometimes youth called upon LAD staff for a kind of help which could be provided by their social worker or other adult who had time to devote to them and many such requests were referred to other persons. Other problems likely would not have been resolved absent LAD's legal identity, expertise, and function. The following cases (disguised to protect the identity of youth involved) illustrate real situations in which LAD appeared to make a significant, even crucial difference:

(1) Two boys who had been in the armed services briefly before their commitment to institutions were notified that they were going to be given dishonorable discharges but had a right to a hearing on the matter. LAD represented these youths and negotiated general discharges from the armed services for them.

(2) A juvenile was receiving social security benefits which were paid to his mother. Following the juvenile's placement in a group home, the mother refused to use or retain such monies for his benefit. LAD effected arrangements for these monies to be received by his parole officer in the juvenile's behalf.

(3) A young man, over 18 years of age but who had been committed as a juvenile, became a defendant in a paternity suit brought by the public welfare department. He wished to admit paternity of his girl friend's baby but feared to do so out of uncertainty as to possible legal consequences. Through LAD services, paternity was admitted and a satisfactory support plan evolved. A court hearing was avoided and a possible irrevocable break in the relationship of the young people averted.

(4) A young lady, orphaned twice by her natural and adoptive parents, inherited a few thousand dollars which would come to her when she turned 18. Her half-interest in the family home had been squandered by an older brother who was trying to secure control of her other inheritance as well. The girl refused to sue the brother, but LAD was able to get the money placed in savings accounts and certificates which were beyond the brother's reach.

(5) A young, pregnant girl wished to marry the father of her baby but could not do so without the consent of her parents. LAD petitioned the court requesting permission for her to marry. Although the court denied the petition, the action convinced the parents of the seriousness of the desire of the young people to be married. They gave permission and the young couple was married.

(6) Two institutionalized boys had clothing and other property which was being held by the owner of a group home in which they had previously resided. Negotiation failing, LAD represented the youths in courts which ordered full compensation for the property.

(7) A county had deducted from a young man's social security benefits the costs of his detention in a juvenile center. It was the opinion of LAD that such use of social security monies was not authorized. Following negotiations the money was refunded.

(8) A girl, estranged from her adoptive parents, was determined to have their parental rights terminated. Provision of the legal assistance necessary to take the action required to achieve this purpose stimulated the girl to review her real desires and situation. As a result she decided not to proceed with the action but to try to develop a better relationship with the adoptive parents.

These few cases, illustrative of many problems brought to LAD, could be multiplied many times. Although no prediction can be made as to what would have happened to these young people relative to these specific problems if LAD services had not been available, it is clear that outcomes would have been much less favorable in most instances.

Institutional Change

A different kind of benefit for youth accrued out of the influence which LAD exerted upon programming for youth who are placed in the facilities served by the project. This refers to the sometimes intangible but nonetheless real impact of LAD upon the whole complex of human roles and relationships in the institutional or group home component of the juvenile justice system. Specifically this impact can be analyzed in terms of (1) its effect upon the self-image of the juvenile, (2) protection for youth against neglect and abuse and violation of legal rights, and (3) its contribution to upgrading fairness and equity for all concerned.

It is impossible to document the precise impact that the provision of a legal service may have upon the self-image of potential or actual juvenile clients. But certainly some positive message is conveyed to youth when society provides a legal service designed for their use and protection. The majority of youth placed in correctional institutions or group homes are in some conflict with the institutions of society—the family, the school, the police, the juvenile court, the institution or group home in which they are residing. From the youth's perspective, some or all these institutions are arrayed against him, and all the power appears to be on their side. The introduction of an agency whose mission is to take his side and represent his interests evokes an extremely positive response from many youth. Staff may be provoked when a juvenile threatens, "I'll talk to my lawyer," but the comment may reflect a relationship which enhances the juvenile's self-esteem and feeling of security. A person who has a lawyer has someone to defend him—someone perceived as being wholly on his side.

Many youth service workers may feel that they are playing the advocate role for these young people, and it is true that they do have the best interests of the young people at heart. Many have close relationships to the juveniles, are liked by them and are willing to do battle in their behalf. Even so, the youth's relationship to a legal representative or advocate is different. Detailed analysis of the differences is beyond the scope of this report but they exist and should be cognized. The youth worker represents some agency in society which is trying to help the young person to adjust to society's demands. An effective youth worker will try to bridge the gap through the development of a personal relationship to the juvenile, but he represents his agency as well as what he perceives as the best interests of the juvenile. Both the worker and his client must recognize the dual responsibility which the worker must carry. He can never become totally the agent of the juvenile he attempts to serve. From the viewpoint of the juvenile, the lawyer is his representative without concurrent responsibility to a welfare, educational, or correctional agency.

Society usually assumes that it is the juvenile who is out of step when he experiences difficulty in the family, at school, or while in the care of a "treatment" agency, and often this is true. But not infrequently the trouble may lie at least in part in some unreasonable or at least inflexible rule or demand imposed upon youth. Faced with such a situation, the youth must simply conform, albeit with repressed anger and resentment, or fight back. Usually he has no other viable options since social institutions tend to be quite resistive to change, and even the most flexible administrator has difficulty in adjusting group programs to fit any unusual individual need.

Youth welfare agencies deal with large numbers of young people, often in groups, and rules and procedures have to be geared to the usual rather than the exceptional case. Even under good leadership, agency rules and procedures tend to become rigid and mechanical. Subject to varied demands by clientele, agencies often become defensive and resistive to change. Rules sometimes are defended because they exist rather than judged by what they contribute or fail to contribute to the maintenance of necessary routines. Inherent to the functioning of any bureaucratic structure, is the development of certain forces and influences antithetical to the goals of individualized care and treatment.

Most of the power is in the hands of the system—the police, the juvenile court, the probation or parole officer, the child-caring institution or group home, and this is as it must be if these agencies are to discharge their respective responsibilities. But power needs to be carefully and continually subjected to checks and to restraints. The juvenile, simply because he is a juvenile and a minor as well as a ward, is in a disadvantaged position in negotiating with an agency official to achieve any special benefit or even the correction of an injustice. Complaints may be resented and tend to aggravate a problem relationship. Youth sometimes may simply accept even gross injustices rather than risk the possible consequences of complaints. Nor are youth sufficiently sophisticated to organize themselves for the purpose of exerting any collective leverage to achieve social change.

These observations point up the crucial need for some form of intervention in behalf of the young people served in group care. This is not to indict the agencies operating these facilities but simply to recognize that even the most progressive institution becomes set in its way and even the most humane agency worker cannot always remain sensitive and responsive to individual feelings and needs. Intervention in behalf of a juvenile frequently exposed some policy or practice which appeared detrimental to the program and which could be modified to the benefit of all. Some resulting changes were welcomed, even stimulated by the agency staff involved. The Hennepin County Home School revised its mail policy with the assistance of the LAD attorneys after the need was indicated by staff. Subsequent negotiations between the juvenile court judge, staff, and LAD attorneys resulted in a new mail policy that was acceptable to all parties. As indicated earlier, on numerous occasions LAD representatives were consulted by staff in every facility served on questions relating to legal rights of both staff and youth and the requirements of due process. Some problem situations were promptly remedied after LAD called attention to legally defective or inadequate practices. LAD discovered that no less than 70 incarcerated youth had been committed after a court hearing where they had been represented only by a student intern without attorney supervision. This resulted in the allocation of funds by the county to provide for adequate public defender services for juveniles.

At one institution it was discovered that youth were not being informed adequately regarding their right to a hearing if they were subject to parole revocation. Initiative was taken by LAD to effect preparation of a daily population sheet which listed parole returnees, a device which enabled public defenders assigned to this institution to quickly identify youth they needed to contact about the parole revocation process.

One of the most complex and difficult problems LAD confronted grew out of allegations made by several boys residing in one institution that they were subjected to physical abuse. Investigation of these complaints indicated that a few staff members quite frequently resorted to the use of physical force in coping with the behavior of rebellious youth. It is accepted generally that the use of reasonable force to restrain a boy who is out of control and in danger of injuring others, himself, or property is not only justified but required. But many of the complaints received alleged that the physical force employed went so far beyond its use to impose reasonable restraints as to constitute physical assaults. In accordance with LAD policy, these complaints were brought to the attention of the institution, including its administrators and the staff involved.

Attempts to negotiate modification of these practices proceded slowly and laboriously. Some of the line staff involved were defensive and this was to be expected. Decisive administrative action was impeded by the pending retirement of the institution's superintendent with all that such a development implies in terms of leadership vacuum and loss of administrative direction. Before the termination of the LAD program, this problem was resolved or at least substantially ameliorated through the promulgation of a new and tough policy designed to insure that the use of physical force would be restricted to that required to impose reasonable restraints upon the juvenile who is momentarily out of control. Revitalized leadership was achieved by appointment of a new superintendent.

A number of other very basic improvements were made in upgrading the program of this institution. These included the elimination of a detention or security unit which was the site of many of the alleged staff assaults. Other changes included modification of a reward and punishment system which seemed unfair, and in practices related to medical care, food service, work duties and the handling of inmate wages. LAD was not alone in working toward achievement of these changes. An organized community committee, the Minnesota Department of Corrections, and some staff within the institution were pushing for many of the same goals. But it appears both fair and valid to conclude that these changes would not have come about at this point in time absent the concrete information about problems and practices which grew out of the LAD program. LAD was thus able to serve as a stimulus for action by other community groups and also to provide leverage by threat of resort to court action in behalf of the young people who were allegedly abused.

Although the problems confronting LAD in trying to help this institution change its program in a positive direction were difficult and complex, it should be noted that LAD's efforts were ultimately more successful than in certain other situations where the problems were less gross albeit very real. One institution served by the project virtually nullified LAD's attempts to address certain negative child care practices, primarily by adopting a course of passive resistance. LAD representatives were made to feel unwelcome. Access to the juveniles was limited in a variety of ways. It was believed, though not proved, that juveniles were pressured not to request assistance from LAD. The negative practices referred to were sometimes subtle and not easily resolved into clear-cut legal issues which could be effectively presented to a court in an effort to secure judicial relief.

Agency Response to LAD

Responses to LAD varied sharply among the agencies operating the facilities which the program served. All were contacted during the course of its planning and all agreed to cooperate. At the same time concern and some anxiety was expressed about the proposal. "What would a lawyer do here?" was an often voiced inquiry. But any concern felt by some agencies subsided quickly after they met with LAD staff and became convinced that they could work cooperatively with them. At the conclusion of the program a member of the administrative staff at the Hennepin County Home School stated: "LAD represented the legal interests of individual youth and proved a helpful ongrounds resource to staff in responding to legal aspects of policy and program affecting our clientele. My . . . suggestion would be to expand the services." The spirit of this comment was repeated in reactions received from several other of the cooperating agencies.

A few agencies became increasingly hostile toward LAD as time passed, even some which had experienced little or no conflict with LAD personnel. This reaction may reflect, at least in part, a lack of sufficient information by institution and group home staff about the program. Materials should have been prepared which could have been given to agency personnel in advance to define and clarify the LAD function and how it would be carried out. In some instances agencies' expectations of LAD, both good and bad, were unrealistic. As a result, the program was blamed sometimes not for what it did do but for what it did not do.

It is our belief that some negative reactions to LAD by agency personnel reflect a response which could be modified by training. For many people in our society, the lawyer image is somewhat negative. The lawyer is the prosecutor, the judge. His image is threatening; he is a figure to be avoided unless you need him to get you out of some difficulty, and then he is likely to cost you a lot of money. These are generalizations, but to a greater or lesser extent they color the reactions of many people to representatives of the legal profession.

Such reactions may be exaggerated by simple ignorance of the law. When a juvenile threatens to call his lawyer because of some staff action, the staff need to have the reassurance which grows out of understanding both of their legal status in performing their job and of their own rights and responsibilities in relation to those of the juvenile with whom they are interacting. The goal here should not be to make jail house lawyers out of staff, but to give them sufficient familiarity with the law to recognize the general boundaries which define lawful action vs. action which may infringe another's rights.

Both the development of a more positive image of persons providing legal services as well as providing sound information on the relevant law could be achieved through training of agency personnel. Some training of this kind resulted from agency personnel's contacts with the LAD program, primarily out of informal give and take discussions with LAD staff. But many interrelationship problems could have been averted or at least minimized had it been possible to organize and offer a formal training program for agency personnel in preparation for launching the program.

Conclusion

The experience of this program illustrates the dilemma confronting this kind of programming. No group of consumers are more in need of advocates and counsel than young people who are the wards as well as the responsibilities of the State. A moderate and tempered style of advocacy meets the need where the treaters and custodians are relatively secure in their roles, openminded, and sensitive to the feelings of youth. These also are the settings where the need for advocates is least. The more aggressive advocacy including resort to court action which seems necessary in other settings builds resistances and resentments which may prove destructive not only to longtime program survival but even for some youth who may experience a backlash from the agency by seeking legal services or aid.

Funding for LAD was terminated after 1 year. It fell victim to some growing feeling within government circles that the State should not fund legal services which might take action against agencies of the State. Although LAD itself did not represent youth in action against a public agency, it was associated in public thinking with related programs which had successfully represented clients in such actions. And certainly the threat of resort to the courts for resolution of client-agency disputes was inherently present even though nonexpressed.

The lesson seems clear. Not only do youth need advocacy which includes the provision of legal counsel and service, but means must be found to provide the necessary service to such disadvantaged client groups without subjecting the program to the continuing threats of possible termination for lack of financial support.

Evaluation of Adult Diversion Programs: The California Experience[*]

A YOUTH PROJECT PROGRAM

PROJECT CONCERN

Research and Advocacy for California Children in Community Care

SURVEY OF GROUP HOME PUBLIC FILES MAINTAINED BY LICENSING & CERTIFICATION OF THE DEPARTMENT OF SOCIAL SERVICES

OCTOBER 24, 1978

Project Concern, a child advocacy research and organizing project, was formed to improve the care children receive while in the out-of-home placement system by monitoring aspects of the system and disseminating information on our findings. We are a program of the Youth Project (Western Regional Office), and were funded for this study by the Field Foundation.

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TABLE OF CONTENTS

Page Nos.

- INTRODUCTION TO STUDY 1- 3
  - Origin of Project Concern and Licensing Files Survey
  - Focus of Study
- LICENSING OF COMMUNITY CARE FACILITIES: LEGAL AND REGULATORY BACKGROUND.................................... 4- 5
  - Community Care Regulations
- PRIOR LICENSING STUDIES.................................... 6- 7
- PUBLIC FILES SURVEY RESULTS.................................... 8-16
  - Summary of Major Findings
  - Study Results: What Information is Public in Group Home Facility Files?
  - Survey Results: Public Forms required on file.
  - Survey Results: Plans of Operation required.
  - Survey Results: Report of Field Visits.
  - Survey Results: Confidential Information.
- USEFULNESS OF PUBLIC FILES TO CHILD ADVOCATES AND CONSUMERS.................................... 17-18
  - What Can Public Files Tell Us About a Facility and the Care Received in a Program?
  - Is There Information, in Addition to that Which is Legally Required, that Should be in a Public Facility File?
- REPORT RECOMMENDATIONS: STEPS THAT CAN BE TAKEN........ 19-20

APPENDIX I : SURVEY TARGETS.......................... 21

APPENDIX II : GEOGRAPHICAL DISTRIBUTION OF PUBLIC FACILITY FILES.......................... 22

APPENDIX III: LIC 809 BREAKDOWN.......................... 23-24

INTRODUCTION TO STUDY

This report is the result of a survey of public files kept on children's group homes by the Department of Social Services (prior to July 1, 1978, the Department of Health).

Over the past few years there has been increasing recognition of problems of poor care and abuse in residential programs.[1] Much attention has focused on the inadequate role the government has played in administering and regulating community care facilities.[2] Concern over the welfare of children in placement has been raised by legislators[3] as well as nationally renowned child advocacy groups like the Children's Defense Fund.[4]

In California, neglectful and abusive program practices have been known to occur. During the four-year period from 1972-76, children at Kate School were subjected to slapping of hands, head, ears, back, mouth, arms, legs, and buttocks. They were spanked with hard instruments, pinched, hit, and shoved. This was done in the name of treatment.* This treatment was never challenged by the licensing worker or the children's social worker. A day aide finally blew the whistle, and thus brought attention to these practices.

[1] See: Wooden, Kenneth, Weeping in the Playtime of Others (New York: McGraw-Hill, 1976).

[2] Taylor, Ron B.; Vanaman, Valerie, State Care of Discarded Children (draft, 1977).

Cohen, Samuel, "Report to the Governor on the Enforcement of Health Care Regulations," (1978).

Commission on California State Government Organization and the Economy, A Study of the Administration of State Health Programs (January, 1976). See Part II, Section G, "Licensing and Certification Programs."

[3] See: California Assembly Committee on Human Resources, "Licensing of Community Care Facilities," report #615, (May, 1977).

California Senate Select Committee on Children and Youth, "Group Home Placement."

[4] Children Without Homes: An Examination of Public Responsibility to Children in Out of Home Care (draft, April 1977). (book to be published at any time.)

*Incredibly enough, at present the most recent court ruling has absolved the facility of any wrongdoing due to vague regulations and difference in professional opinion of what constitutes "treatment."

Project Concern has had contact with many parents of handicapped children and has heard of their concerns regarding placement of children. A recent problem that was brought to our attention is typical. It concerns the placement of a 14 year old retarded girl who was put in a group home while her parents vacationed. They had to cut their vacation short when friends and relatives reported that the girl was unkempt, ill, and had lost weight. Upon their return they verified her condition. She had lost five pounds in five weeks, had two infections, and two-fifths of her clothes were missing. Once home, according to her mother, she ate ravenously for three days. The mother is presently pursuing her complaint even though her Regional Center Social Worker at first tried to discourage her.

Examples of fraudulant practices have also been documented.

Recently one child was diagnosed in need of treatment and placed at a residential school for $1,271 a month. The school then subcontracted him to an unlicensed family home for which they paid $350.00 a month. It appears the school kept receiving the $1,271 a month, in essence pocketing $921 after they paid the family home ... With financial deals of this sort occurring, where is the concern for meeting the child's needs?

ORIGIN OF PROJECT CONCERN AND LICENSING FILES SURVEY

Project Concern was formed to investigate how such practices could occur. California is recognized as a pacesetter in legal regulation of placement facilities, and yet poor and dangerous programs have developed and operated for years without discovery. How do bad programs or poor practices within programs exist? Does the Licensing and Certification Division enforce the law and regulations? How can outside individuals or groups of child advocates monitor the care children receive?

These are not easily answered questions. Project Concern chose as a primary focus the regulation of facilities by the State. Due to the major state reorganization of the Department of Health this year, it was difficult to survey the policy and practice of out-of-home care from "the top."

We decided to start at the district level and investigate what information already available to the public could tell us about facilities and the regulation of them by the Licensing and Certification Division. We reasoned that determining what was already available for inspection would be a first step in establishing a procedure for systematic monitoring of facilities by those outside the regulatory system.

FOCUS OF STUDY

The purpose of this study was:

1. To determine what information is publicly available through Licensing and Certification on children's residential programs,
2. to survey a sub-group of public files to monitor the degree that the public information was, in fact, available, and
3. to assess the degree to which public information is indicative of the actual operations of the program. In other words, can the public files of Licensing and Certification be of any use to child advocates in monitoring the type and quality of out-of-home care children receive?

LICENSING OF COMMUNITY CARE FACILITIES: LEGAL AND REGULATORY BACKGROUND

There are currently estimated to be over 28,000 children in out-of-home placement in California. The majority of these young people are placed in homes and facilities licensed by the State of California.*

STATE LAW

The current statute authorizing licensing and regulation of community care programs is the 1973 Community Care Facilities Act (AB2262). It was passed in recognition of the need to "establish a coordinated, comprehensive, state-wide service system of quality community care for the mentally ill, developmentally and physically disabled, and children and adults who require care or services in a facility or organization..." The act consolidated three separate facility licensing programs: the State Department of Social Welfare, the State Department of Mental Hygiene, and the State Department of Public Health. The consolidation designated the Department of Health as the state agency to carry out the law and as of July 1978 this responsibility has been transferred to the Department of Social Services.

Among other things, the law mandated: 1) periodic inspection and evaluation of facilities by a designated state agency; 2) development of evaluation methods, including a system to rate the quality of facilities; 3) a penalty system for noncompliance with regulations; 4) criteria and procedures for suspension and revocation of licenses; 5) protection of complainants against retaliation; 6) state provided consulting services to assist facilities in identifying and correcting violation of regulations.

An important aspect of the law was the provision allowing public inspection of records. The law states, "reports on the results of each inspection, evaluation, or consultation shall be kept on file in the State Department and all inspection reports, consultation reports, lists of deficiencies, and plans of correction shall be open to public inspection ..."[5]. This mechanism provides one of the few legally sanctioned channels citizens have to monitor programs serving children and others in need who utilize community care facilities.

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*County juvenile halls and California Youth Authority programs are not licensed by the State.

[5] California Community Care Facilities Act, Section 1534.

COMMUNITY CARE REGULATIONS

The community care regulations (Title 22 California Administrative Code) drafted pursuant to the law and effective August 31, 1975 reaffirmed the public right to inspect facility records. The regulations, while detailing some standards of care and procedures for licensing and enforcement, did not provide a rating system or any mechanism by which to evaluate quality of care. This part of the law has yet to be implemented. In addition, while the regulations did set forth a procedure for civil penalties in cases of noncompliance with regulations, it appears to have never been enforced.

With these two mechanisms for encouraging high standards of care non-existent, the licensing process and the annual inspection and evaluation become the sole regulatory mechanisms in use. Both of these processes should be documentable by surveying the public files. Monitoring of public files by advocate groups provides a way to assess the department's regulatory role and determine by way of this public information how well a facility is operating.

PRIOR LICENSING STUDIES

Project Concern reviewed a number of studies and reports done by various State agencies that evaluated the effectiveness of the Licensing and Certification Division. All reports recognized critical deficiencies in the Department's operations. Comments from those reports that are most relevant to this study are reviewed here.

A 1977 report from the OFFICE OF THE AUDITOR GENERAL found that "understaffing and inappropriate caseload standards in licensing and certification impede, 1) timeliness of evaluations (of facilities), 2) compliance with community care evaluation requirements, 3) the division's ability to assure an adequate level of care for residents of the facility." They found that all of the nine districts surveyed were not adequately[6] conducting follow-up visits to insure violations were corrected.

The report emphasized that the lack of annual inspections and follow-ups may "adversely impact on the quality of care or endanger residents." In clarifying potential dangers they listed three examples of dangerous situations that had been identified during annual inspections: 1) an adolescent mentally retarded girl was found living in a facility licensed for mentally disordered adults, 2) fresh food was improperly refrigerated and exposed to vermin, 3) drugs were improperly secured and labeled.

Unfortunately, this was not the first report criticizing the Licensing and Certification Division for not implementing the 1973 Community Care Facililities Act. The PROGRAM EVALUATION UNIT OF THE DEPARTMENT OF FINANCE did a study in August 1976 on the activities performed by the community care unit. (Children's group homes are licensed and evaluated for care through this program.) Aspects of the law they cited as not enforced relating to residential facilities were: 1) final regulations and standards for 85% of the community care facilities (foster homes--but not group homes, were included in this figure). 2) an equitable and uniform method of evaluating the quality of care and services provided by each category of community care facility. 3) civil penalties levied against facilities upon finding them in noncompliance.[7]

A 1977 DEPARTMENT OF FINANCE STUDY found 1) no priority had been assigned to meeting the requirement in the law for annual visits, which were always the lowest priority behind handling complaints and new licenses. 2) no procedures for levying civil fines had yet been developed. The report also identified examples of unfinished staff work: projects begun and not yet or fully implemented. Included in this list were management of complaints, the workbook-quality rating system, fines and misdemeanor procedures, and last but certainly not least the issuing of regulations to

[6] "Opportunities to Improve the Department of Health Evaluation of Community Care Facilities." Report Number 722.

[7] "Department of Health Licensing of Small Community Care Facilities." Report Number H636D.

fully implement the law and subsequent legislation.[8] In their survey of 142 facilities, over half had not had an evaluation visit in over two years.

Lack of legally required evaluations was also verified in the May 1977 hearings before the Assembly committee on Human Resources.[9] (see page 110,100).

As these studies have amply demonstrated, the Community Care Facilities Act has yet to be fully implemented, and even where procedure exists, shortage of trained staff and departmental inefficiency have prevented regular state monitoring and evaluation of community care programs. Who assures the well-being of children in residential care? It appears that no one does.

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[8] "Staffing for State Level Licensing of Community Care Facilities."

[9] "Licensing of Community Care Facilities," p. 100,110. Orange County had 75 residential facilities that had not been visited in two years; a Fresno district office worker testified that 70-75% of the facilities on his caseload had no annual site visit.

PUBLIC FILES SURVEY RESULTS

SUMMARY OF MAJOR FINDINGS

To determine how well the facility files are set up and maintained, Project Concern surveyed 42 children's group home files in three district offices. This total accounted for about one-third of all group homes in the Berkeley, San Francisco, and San Jose District offices.* We reviewed over 248 state licensing documents, 180 Reports of Field Visit (LIC 809), and a number of documents written and submitted by the facilities/licensee.

Some of the survey findings are:

- a total of 333 public documents are missing from 42 files;
- 7 of 42 children's group homes have no indication of being cleared for fire safety in over two years;
- of ten complaints against the facilities reviewed (recorded on LIC 809), one was substantiated, five were unclear as to their resolution. Only four were unsubstantiated;
- 29 items were found in public files that are designated as confidential by California State Statute or Department of Health Policy;
- 11 of 42 facility files have no annual inspection report (LIC 809) over the three-year period from 1976 through mid-1978;
- 58 annual inspection reports (LIC 809) were not in the files.

Project Concern finds these facts disturbing, and is concerned about how these results reflect on State monitoring of community care facilities, specifically group homes for children. It is highly unlikely that 333 forms have been misfiled. The evidence points to uneven collection of required information, lack of annual site visits, and careless filing of information that is confidential.

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*Although, due to administrative autonomy of the district offices, it is impossible to generalize these results to all districts. Project Concern feels the problems consistently identified in the three districts surveyed suggest that similar problems exist at other district offices. See Appendix I for explanation on why were group homes selected for this study.

We found a lack of coordination on the organization and use of the files within and between the district offices. Our survey revealed the following examples of inconsistencies and contradictions in district offices' facility file procedures:

- no information in the "personnel," "finance," and "physical plant" sections....Berkeley (Berk.), San Francisco (S.F.), San Jose (S.J.)
- badly disorganized files....Berk., S.F., S.J.
- LIC 809* used for office notes....Berk., S.F., S.J.
- failure to enforce the facility license renewal deadline....S.J. will cite the facility for non-compliance of s/s 80135 of the community Care regs., and S.F. will consider it an oversight of the computer and the evaluator;
- filing the LIC 500 in the confidential file if it contains the info. on the employees wages or salary....S.J., (but the survey found several LIC 500 in this offices' files that contained such info.)
- total lack of any LIC 809 on file for a facility ....Berk., S.J.
- lack of facility evaluator signature on LIC 809 ....S.F., S.J.
- facility requested to respond to deficiencies reported on LIC 809 within specific time--no response/follow up on file....S.F.
- report of a field visit written up on note paper and binderpaper without s/s citations or signatures....Berk.
- LIC 809 used to write up death/unusual injury report....S.F.

STUDY RESULTS: WHAT INFORMATION IS PUBLIC IN GROUP HOME FACILITY FILES?

The Licensing and Certification Division of the Department of Social Services is responsible for the organization and maintenance of a public file, known as a facility file, on each licensee. Our attempts to find out what public information should be found in this file were frustrated as there is no current comprehensive description of what information kept by the Division is public or confidential. Interviews with officials and workers at the district and state level revealed inconsistent interpretations as to what was public. Two evaluators and a supervisor at one district office knew of no written policy on what was public information.

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*Content of required forms are explained later in report.

Our research identified an operations memo of April 16, 1975 that incidentally stated what filings were public and confidential.[10] This memo was verified as still operational by the Field Operations Bureau Chief of Licensing and Certification Division.

Utilizing the above-mentioned memo, as well as laws and regulations, we determined the following information was public.[11]

1. Required Licensing Forms:

LIC102	Sanitation Inspection Request
105	Fire Clearance Request
LIC118	Fire Safety Inspection Request
LIC200	Application for Facility License
201	Application for Facility License Renewal
203	License
LIC300	List of Board Officers
308	Designation of Administrative Responsibility
309	Administrative Organization
LIC400	Affidavits Regarding Client Monies
401	Estimated Operating Budget
402	Surety Bond
403	Financial Statement
404	Financial Information Release
LIC500	Personnel Summary
502	Personnel & Qualifications Report
LIC600	Death/Injury Report
610	Facility Medical Coverage
LIC809	Report of Field Visit

The information listed on the following page, although never specifically identified in memo or regulations as public, routinely appears in the public files and so is treated as public information. This information is required by Licensing and Certification on facilities of 16 or more residents per sub-section 80307 of the Title 22 Regulations.*

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[10] Department of Health Operations Memo #36.

[11] Title 22 California Administative Code: Licensing of Community Care Facilities, sub-section 80353(e); Licensing & Certification Division Operations Manual sub-section 117-2303.

*Although this detailed information is only required for facilities with a population of 16 or more, it became apparent during our research that it is often submitted and found the facility files of facilities with a resident population of less than 16.

(1) Statement of purpose, program goals, and description of basic services; and any specialized services,

(2) Statement of admission policies and procedures; statement that the facility is non-discriminatory,

(3) Administrative organization,

(4) Staffing plan, qualifications and duties,

(5) Plan for inservice training of staff,

(6) Sketch of physical facility...drawn to scale,

(7) The time of day meals and snacks are served, and menus,

(8) Hours of operation,

(9) Transportation arrangements....,

(10) Rate-setting policy, including....refunds,

(11) Arrangements for handling residents' funds.

This material is to be submitted with a written plan of operation and kept current.

2. Report of Field Visits (LIC 809)

This state form is used by licensing workers to record observations made during the annual inspection visit or, at any other time, the evaluator checks in on the program. The form records any citations for violation of Title 22 Regulations (deficiency/comments section), and should also have a plan of action for correction of deficiencies within a specified period of time (recommendations & corrections section). The 809 should be signed by the evaluator and the Facility Director or a staff who receives the 809 from the licensing evaluator.

In the records kept on community care facilities, this is certainly the most important item as it is the evaluation tool that identifies program deficiencies and sets plans for improvement. As a public record it is potentially an important advocate's tool for assessment of program practice over time. Unfortunately, because annual inspections are still not routinely done and due to illegibility* of many 809's their utility is at present almost nil.

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*Although it is "common sense" to have readable reports, the Licensing and Certification Operations Manual specifically states 809's are to be clear and legible...

SURVEY RESULTS

PUBLIC FORMS REQUIRED ON FILE.

- OUT OF A TOTAL OF 581 POSSIBLE DOCUMENTS TO BE ON FILE, ONLY 248 WERE IN FILES. 333 WERE MISSING.

DOCUMENT TITLE:	TOTALS BY DISTRICT OFFICE BERK.	S.F.	S.J.	TOTALS: IN FILE/MISSING
License Application (LIC200)	11	8	13	32/10
License Renewal (LIC201)	13	11	13	37/5
Current License (LIC203)	13	12	12	37/5
Sanitation Inspection Request (LIC102)	0	3	8*	11/29
Fire Clearance Request within 2 years (LIC103)	11	11	11*	33/7
Board Officers (LIC300)	5	5	1	11/29
Designation of Administrative Responsibility (LIC308)	0	3	5	8/34
Administrative Responsibility (LIC309)	3**	3	6	12/29
Affidavits of Monies Handled (LIC400)+	3	5	7	15/27
Estimated Operating Budget (LIC401)	2	7	1	10/32
Financial Statement (LIC403)	1	0	1	2/40

(continued on next page)

* This form in process with 2 facilities, total is 13 possible.

** This form in process with 1 facility, total is 12 possible.

+ If a facility elects to handle more than $50 a month or $500 a year of resident monies, then it must also post a surety bond and submit form Surety Bond (LIC402).

continued:

Personnel Summary (LIC500)	9	6	7	22/20
Personnel and Qualifications (LIC502)	2	6	4	12/30
Facility Medical Coverage (LIC610)	0	0	6	6/36
			TOTAL	248/333

SURVEY RESULTS

PLANS OF OPERATION REQUIRED OF FACILITIES WITH 16 OR MORE RESIDENTS.

Project Concern reviewed six facility files that are required to have special information on plan of operation, due to housing sixteen or more residents.*

- NONE OF THE SIX FILES HAD A COMPLETE PLAN.
- OUT OF 72 POSSIBLE ITEMS TO BE ON FILE, 35 WERE MISSING.

x = missing item

? = not clear information on file

REQUIRED MATERIALS:	B1	SF1	SF2	SJ1	SJ2	SJ3
1. Purpose						x
2. Admissions procedure		x	x			x
3. Admission policy		x	x			x
4. Non-discriminatory statement			x		x	x
5. Administrative organization		?		?	?	?
6. Plan for staff education		x	x	x	x	x
7. Physical layout of facility			x		x	
8. Meal service and menus	x				x	
9. Hours of operation	x	x	x	x	x	x
10. Transportation plans		x	x	x	x	x
11. Rate setting policy	x	x	x	x	x	x
12. Handling of residents' funds (recognized LIC400 as compliance)	x	x			x	

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*Title 22, Division 6, sub-section 80307, Calif. Admin. Code.

SURVEY RESULTS

REPORT OF FIELD VISIT (LIC809)

- 58 ANNUAL INSPECTION REPORTS WERE MISSING.
- 11 FACILITIES HAD NO INSPECTION REPORT ON FILE FOR 1976, 1977, or 1978. THREE YEARS WITHOUT EVALUATION OR FORMAL MONITORING.
- THERE WERE ONLY 11 INSTANCES IN WHICH THE DEPARTMENT FOLLOWED UP TO INSURE THAT PLANS OF CORRECTION WERE IMPLEMENTED.

FIELD REPORT CITATIONS:

TIME IN OPERATION SINCE COMMUNITY CARE FACILITIES' REGULATIONS:

	1975 (Sept. thru Dec.)	1976	1977	1978 (Jan. thru July)	TOTALS:
# of Deficiencies Cited	10	96	120	50	276
# of Corrections Listed	7	78	95	28	208
Indication of Follow-up*	2	4	3	2	11
Facility Files without Annual Inspection (LIC809)	n/a	11**	19	28	58

Also, there were 102 Reports of Field Visit without a facility representative signature in some cases on reports with deficiencies cited. There were 51 report forms used for purposes other than field visits, such as office notes on pre-licensing procedures and phone conversations with facility operators.

* not a one-to-one ratio to deficiencies and correction figures; i.e., one follow-up could cover checking on more than one s/s violation.

** these 11 facilities lacked 809's for 1976, 1977, 1978.

SURVEY RESULTS

CONFIDENTIAL INFORMATION

- THERE WERE 29 INSTANCES OF CONFIDENTIAL MATERIALS FOUND IN THE FACILITY FILE.
- SAN FRANCISCO AND SAN JOSE FILES HAD THE MOST ITEMS, 17 AND 11 RESPECTIVELY.

CONFIDENTIAL ITEMS FOUND:	DISTRICT OFFICE NUMBER OF INSTANCES:		
	BERK.	S.F.	S.J.
1. Licensing Questionnaire* (LIC209)	0	0	1
2. Applicant Information* (LIC215)	0	0	3
3. Personnel Record* (LIC501)	0	4	4
4. Pre-employment Exam.* (LIC503)	0	0	1
5. Contact Sheet with Client's/Resident's Name on It**	0	2	0
6. Correspondence with Client's/Resident's Name**	1	7	0
7. Complainant's Name+	0	1	0
8. Medical Records of Client/Resident++	0	1	0
9. Financial Worth Records of Licensee++	0	2	2

* Operations Memo #36, Department of Health

** s/s 10850, Welfare and Inst. Code

+ s/s 1538(b)(c) Health and Safety Code; s/s 112-2705.1 Div. Operations Manual

++ s/s 6253.5(e), Chap. 3.5, Gov't. Code

USEFULNESS OF PUBLIC FILES TO CHILD ADVOCATES AND CONSUMERS

California is well ahead of most states in having clearly articulated laws governing access to information deemed "public." This holds true regarding licensing of community care facilities and the existence of public files on these programs. This right to receive information about out-of-home placements is important and it supports the citizens' right to know what goes on in such programs.

This information could provide a means for child advocates to monitor programs as well as provide a vehicle for potential consumers to use in locating appropriate programs. As regards to the latter, there is currently no system, public or private, to assist parents and agencies in identifying community care programs. The Community Care Facilities Directory put out by Licensing and Certification is supposed to assist in this process, but without the rating system or specific information on programs, the Directory is simply a list and, as such, not very useful. The major system for information on programs is informal, by word of mouth. While this is not necessarily bad, those outside of information networks don't have any access to what programs are available and which are good or bad.

WHAT CAN PUBLIC FILES TELL US ABOUT A FACILITY AND THE CARE RECEIVED IN A PROGRAM?

As this report documents, the public facility files are currently of little use to child advocates and potential consumers. However, if they were kept in a consistent form, providing information required by law and regulation, they could provide a baseline of valuable information. By checking a file, an individual or agency could find out:

- who operates the facility
- who it is set up to serve
- the type of staff (including qualifications)
- program goals and philosophy*
- typical menus and meal schedules*

In addition, certain evaluative information would be present:

- yearly annual evaluations (LIC 809's) stating any regulatory violations and if an how/when they were corrected

*At present, this information is only required for group homes licensed for 16 or more.

- if relevant record of investigations of complaints on the program
- records of fire and sanitation inspections, indicating if the facility meets/ doesn't meet these codes

Clearly, this type of information would be useful were it present. It would not be an end all guarantee of the nature and quality of a facility, but would provide baseline information. For the consumer, this would help narrowing the scope in the search for an adequate program*

For the child advocate, an organized public file could be another check point when monitoring the operation of a particular program and, perhaps most importantly, a means to monitor Licensing and Certification operations. The present disorganization of public files makes it impossible to ascertain the state of a facility; the only thing that is clear is that Licensing and Certification is not maintaining files nor completing annual inspections.

IS THERE INFORMATION, IN ADDITION TO THAT WHICH IS LEGALLY REQUIRED, THAT SHOULD BE IN A PUBLIC FACILITY FILE?

It would be helpful to have some additional information in a public facility file. None of the information we recommend violates confidentiality or the Privacy Act.

Firstly, we feel it is important that the file indicates the names of agencies that regularly place in the facility. This information can be helpful as it indicates how many agencies have worked out satisfactory ongoing relations with the facility. It also makes it possible to contact placing agencies. A parent may want to have another opinion on how the place operates and who it best serves. An advocate who has heard complaints on a facility could check and receive the placement agency's opinion.

Secondly, the file should clearly state the status of follow-ups on reviews and list any ongoing problems the facility is having in meeting regulations. This is just plain consumer protection. Prospective consumers and advocates have the right to know how a facility is conforming to law and regulations. Perhaps, both of these suggestions could be incorporated on a revised 809 Report of Field Visit Form.

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*Unfortunately, for many children in need of group care, there is no appropriate program. This problem needs a separate study to consider it.

REPORT RECOMMENDATIONS: STEPS THAT CAN BE TAKEN

We think the following recommendations are realistic, "Prop 13 conscious," small steps that CAN be taken without major cost outlays. Because they are moderate changes, most simply requiring the Department to do what it should have been doing all along, we trust they will be given serious consideration. If not implemented, we would like to know why and what alternatives the Department puts forth to correct the problems identified in this report.

1. The Department of Licensing and Certification should establish a policy on public and confidential documents as part of its field operations manual.

2. Copies of a clear, specific policy on public and confidential information should be given to each district office evaluator, supervisor, administrator and clerical worker.

3. This policy should be available upon request at the district office and notice of its availability should be made in the directory of facilities.

4. A clear, written procedure for the maintenance of public (and private) files should be developed by central administration. All district offices should be required to utilize one procedure.

5. District offices should perform an annual inspection of every facility as required by law. Although this recommendation is an often heard refrain over the past five years, nothing has changed. With Licensing and Certification now under the Department of Social Services, we expect to see a new approach to ensuring enforcement of Community Care Regulations. Toward this end we recommend:

   (a) A quarterly print outs of facilities up for their annual inspection. The district office should be be required to file these print outs in Sacramento the month after the quarter ends indicating which facilities did, in fact, have an annual inspection. This report should be available to the public.

(b) More effective procedures should be developed to ensure facilities file required forms.* Facilities should be informed of what is required and supplied with forms and instructions. Evaluators should be responsible for assuring required forms are turned in to the district office. Facilities should be penalized for failure to file required documents as set forth in Title 22 Regulations. This system should also include a mechanism to insure that forms are refiled once information becomes obsolete. All material should be updated at least annually. (Although not stressed in this study, it is clear that many forms are not updated and hence, become useless.)

6. To assist consumers and advocates the Department policy should require that the following information be in the public facility file:

   (a) Names of agencies that regularly place at the facility.

   (b) The status of Department follow-ups on evaluative reviews and a list on any ongoing problems the facility is having in meeting regulations.

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*This legally required information can provide vital information to Licensing and Certification potential consumers, and child advocates about who operates a program, what type of staff is used and the program philosophy.

Appendix 1

SURVEY TARGETS

Three district licensing offices group home files were surveyed. We looked at approximately one-third of the group home files in each district and attempted to pick homes that were distributed throughout the district areas geographically.[12]

Group homes were chosen as a sub-group of all out-of-home placements for a number of reasons. Firstly, most operate with paid staff and are larger and more institutional than "mom and pop" placements. Most take severely disturbed or handicapped children who are dependent on the program and vulnerable to abuse or neglect. One recent study of out-of-home care in nine states, including California, found that "the further child is from a family context, the less caseworker-child contact is required."[13] Children in group placements, especially larger facilities are more likely to be isolated from those who could potentially advocate for them.

Secondly, group placements are generally handled directly by the State Licensing and Certification Division and not contracted out to counties as many foster homes and foster family homes are. This insured the study looked at public files of facilities directly regulated by one source.

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[12] See Appendix II for District locale and geographical distribution.

[13] Children's Defense Fund, op.cit. p.20

Appendix II

GEOGRAPHICAL DISTRIBUTION OF PUBLIC FACILITY FILES

Approximately one-third of all public files are from the San Francisco, San Jose, and Berkeley district Licensing and Certification Offices. Most facilities were randomly chosen, although a few were selected because the Project had received calls attesting to exceptionally good or bad programs.

The geographical breakdown was as follows:

ALAMEDA COUNTY : Berkeley (1), Fremont (1), Hayward (1), Oakland (4), San Leandro (1).

CONTRA COSTA COUNTY : Concord (2), Lafayette (1), Richmond (2)

MARIN COUNTY : Corte Madera (1) Novato (1), San Anselmo (2), San Raphael (6).

SAN FRANCISCO COUNTY: (6).

SAN MATEO COUNTY : El Granada (1), Hillsborough (1), Redwood City (1).

SANTA CLARA COUNTY : Campbell (1), Cupertino (2), Gilroy (2). Los Gatos (2), Palo Alto (1), San Jose (3).

SANTA CRUZ COUNTY : Aptos (2), Boulder Creek (1), Watsonville (1).

Appendix III

LIC 809 TALLY SHEET BREAKDOWN, ...BERK. S.F. S.J.

The following tables are a breakdown of the number of deficiencies, corrections, follow-ups, and missing reports found in 42 facility files we surveyed in the Berkeley District Offices.

Out of the 29 Reports of Field Visit reviewed, we found that: 5 reports were used for other than a site visit, 16 are without a facility representative signature, and 1 is written in response to a complaint against a children's group home, but it is unclear as to the resolution of the complaint.

	YEAR				
	1975*	1976	1977	1978**	TOTALS
# of Deficiencies Cited . . . . :	9	30	9	0	48
# of Corrections Listed . . . . :	7	28	0	0	35
Indication of Follow-up*** . . . . . :	1	3	0	0	4
# of Facility Files w/o Annual Inspection (LIC 809). . :	n/a	2	11	11	24

(*only September thru December.) (**only January thru July.)

(***not a one-to-one ratio to deficiencies and corrections figures; ie; one follow-up could cover checking on more than one s/s violation.)

In the San Francisco District Office we looked at 14 facility files covering a total of 64 LIC 809's. We found that: 15 reports were used for other than a site visit, 25 are without a facility representative signature, and 2 were written as a response to a complaint about the facility, but they were unclear as to their resolution (substantiated or unsubstantiated). The yearly figures are as follows:

Appendix III (cont'd.)

LIC 809 TALLY SHEET BREAKDOWN, ...BERK. S.F. S.J.

	YEAR				
	1975*	1976	1977	1978**	TOTALS
# of Deficiencies Cited . . . . :	0	23	18	30	71
# of Corrections Listed . . . . :	0	11	8	23	42
Indication of Follow-up*** . . . . . . :	0	1	2	2	5
# of Facility Files w/o Annual Inspection (LIC 809). . :	n/a	5	7	7	19

(*only September thru December.) (**only January thru July.)

(***not a one-to-one ratio to the deficiencies and corrections figures; ie: one follow-up could cover checking on more than one s/s violation.)

And finally in the San Jose District office, we selected 15 facility files with a total of 87 LIC 809 surveyed. In this grouping there were 31 reports that were not a site visit, 61 that were without a facility representative's signature, and 7 reports filed as a response to a complaint. Of those 7 reports, 1 complaint was verified, 4 were unsubstantiated, and 2 were unclear as to their resolution.

	YEAR				
	1975*	1976	1977	1978**	TOTALS
# of Deficiencies Cited . . . . :	1	43	93	20	157
# of Corrections Listed . . . . :	0	39	87	5	5
Indication of Follow-up*** . . . . . . :	1	0	1	0	2
# of Facility Files w/o Annual Inspection (LIC 809). . :	n/a	4	1	10	15

(*, **, *** as above...)

CRC
CALIFORNIA ASSOCIATION OF CHILDREN'S RESIDENTIAL CENTERS INC. — 11th & L Bldg. — 1127 11th Street, Suite 812
BRIAN F. CAHILL, Executive Director — Sacramento, California 95814 — (916) 446-0241

January 4, 1979

The Honorable Alan Cranston
United States Senator
One Hallidie Plaza / Suite 301
San Francisco, CA 94104

Dear Senator Cranston:

The California Association of Children's Residential Centers is delighted that you are holding hearings on problems relating to abuse of children within institutions. Our Association represents 130 separate facilities serving approximately 3500 children in group care in California.

Your hearings are most timely because, as you know, subsequent to Proposition 13, the State of California has assumed 95% of the non-federal share of foster care costs. This includes the cost of children in group care facilities. Hopefully, the State in its role of developing program and rate setting standards, as well as increasing its licensing capacity, will be paying considerably more attention to children in residential group care.

While there is much more that can be said about the role of the State, we would like to limit our comments to the role of county placement, the role of citizen monitors, and the role of group care providers in not only preventing child abuse in institutions, but in creating systems and programs that truly will provide quality care for children who are not able to live in their own homes.

It is our strong opinion that the key decision maker in the entire out-of-home placement process, is the county placement worker. Many welfare departments and probation departments in the State have placement divisions. This type of structure presents the best opportunity to insure that the placement worker has a thorough knowledge of the facilities available for children who need group care. Because of the tremendous discretionary decision making responsibilities of the placement worker, there not only must be a knowledge of the group care facilities but there must be a specific understanding of the types of services provided so that a judgment can be made as to the appropriateness of the services in order to meet the needs of the child. County placement workers and protective service workers are in the best position to see: 1) that only children who truly need group care services are placed; 2) that an appropriate treatment plan is developed for each youngster; and 3) satisfactory quarterly reports are made on the progress of each youngster. The placement worker is in a key position to support good quality care programs. While the license revocation process is sometimes cumbersome, the placement worker, by not placing children in sub-standard programs, can have a lot to say about the continuance of such programs.

The role of trained monitors is crucial. Knowledgeable and constructive organizations such as the San Francisco Child Abuse Council are extremely valuable not only in the prevention of abusive and neglectful practices in group care settings, but in the promotion of true quality standards. The Institutional Child Abuse Project of the San Francisco Abuse Council is a good example. This Project is able to provide training to institutional group care staff on reporting requirements, and can be a valuable resource to group care facilities. It is important to distinguish between such efforts on the one hand and ill-informed, biased efforts on the other hand which are based on the belief that all institutional group settings are bad and no children should be placed in institutions. Aside from the fact that such a viewpoint is unrealistic, it also ignores that deinstitutionalization is a means to achieve quality care for children who cannot live in their own homes. It is not always an end in itself.

Finally, the role of group care providers themselves must be examined thoroughly. It is not enough that a facility meet State licensing requirements. It is not even enough that a facility meet the specific criteria of a local placement division. Group care facilities must be willing to open themselves to scrutiny. They must be committed to full disclosure. They must see themselves as no longer a closed isolated environment, but rather an open family support system that has definite ties to the community. Furthermore, facilities must see the services that they provide as only part of a continuum of child welfare services. Finally, and most important, group care facilities must be willing to govern themselves.

Three years ago, our own Association developed a process of peer review, whereby each agency, in order to maintain its membership in the Association, must submit to a two day on-site review of all aspects of its program. Such a review is also mandatory for any new applicant for membership in the Association. The peer reviews are conducted by colleagues, by fellow executives and program directors from other agencies within the Association. It has been suggested that peer review is not valid, that it is self-serving. We would like to suggest however, that in the three years that our Association has been conducting peer reviews, we have found the opposite to be true. If one stops and thinks, it makes a great deal of sense that the most knowledgeable reviewers of a group care facility are the operators of other group care facilities. These operators at least the ones in our Association, are extremely concerned that the good reputation of their program not be diminished by another program's neglect or abuse. The motivation in our Association to police ourselves is quite high. Peer review is primarily seen as a consultative instrument, a way in which agencies can improve the quality of care they provide. The review looks into the governing body of the organization, finances, organization and administration, personnel practices, the treatment program, and the physical plant. I am enclosing the criteria and the guidelines for the peer review program. We feel that the peer review is a mechanism that should be developed beyond our Association members, as one that can be used anywhere in the country. We are not suggesting that peer review is the only source of accountability. There must be a significant state and federal role played in the standard setting and funding of group care facilities. County placement and trained monitors also play a key role. We are suggesting however, to ignore the potential for group care providers to set their own standards for quality of care is to ignore a source of accountability that can only result in improved standards for children who cannot live in their own homes.

If there is anyway we can work with your staff subsequent to the hearings, we would be more than glad to do so. We appreciate your interest and concern in this issue as well as your long standing and active commitment to child welfare.

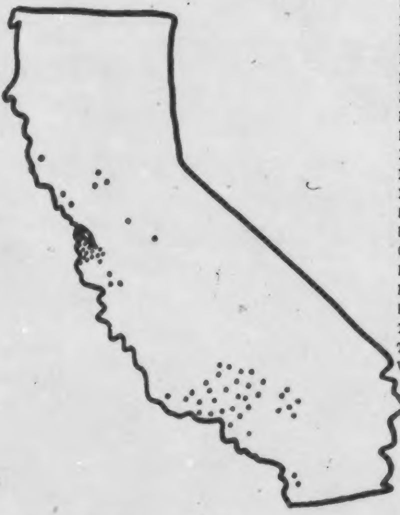
Sincerely,

Brian F. Cahill
Executive Director
California Association of
Children's Residential Centers, Inc.

BFC/rm
encls.

MENDOCINO
Trinity School for Children
SONOMA
Clear Water Ranch
Lane Children's Center
MARIN
Children's Garden
St. Vincent's School
Sunny Hills Children's Services
Youth Advocates
SACRAMENTO
Children's Receiving Home
Sacramento Children's Home
Stanford-Lathrop Memorial Home
SAN FRANCISCO
Burt Center
Catholic Social Services
Charila Foundation
Convent of the Good Shepherd
Edgewood Children's Center
Florence Crittenton Services
Homewood Terrace
Mount St. Joseph's Home for Girls
San Francisco Boys' Home

ALAMEDA
Fred Finch Youth Center
Lincoln Child Center
St. George Homes
SANTA CLARA
Eastfield Children's Center
Ming Quong Children's Center
Odd Fellow-Rebekah Children's Home
SAN JOAQUIN
Children's Home of Stockton
STANISLAUS
Faith Home Teen Ranch
SANTA BARBARA
St. Vincent's School



ORANGE
Florence Crittenton Services
SAN DIEGO
Boys & Girls Aid Society
San Diego Center for Children

LOS ANGELES
Big Sister League
Children's Bureau of Los Angeles
Convent of the Good Shepherd
Children's Baptist Home
David & Margaret Home for Children
El Nido Lodge
Ettie Lee Boys' Home
Five Acres
Florence Crittenton Services
Hamburger Home
Hathaway Home for Children
Hillsides Episcopal Home for Children
Hollygrove
International Orphans
LeRoy Boys' Home
Long Beach Youth Homes
Maryvale
McKinley Home for Boys
Optimist Boys' Home
Pacific Lodge Boys' Home
Rancho San Antonio
Rosemary Cottage
The Sycamores
The Unfinished Symphony Ranch
Vista Del Mar Child Care Services

SAN BERNARDINO
Boys' Republic
Guadalupe Home for Boys
Hillview Acres
RIVERSIDE

Good Samaritan Center
St. John's Home for Boys

The overall goal of CRC is to provide quality care for children in California who cannot live in their own homes. CRC has three basic functions: sharing of information and experience in matters pertaining to the care of the children and the management of the programs; advocacy for the interests of children in residential care; promotion of high standards of care for children's residential programs.

CRC members expend 40 million dollars annually in operating costs. Almost 75% of the funding of those costs comes from public sources, primarily from purchase of service contracts with the counties from which the children are served. Tax deductible donations, bequests, United Way contributions, and income from endowments and private fund raising comprise 25% of the funding sources. The land and buildings in which CRC members operate their programs, have been developed almost entirely from private funds. The current value of CRC buildings and land is 65 million dollars.

Membership in CRC is open to any nonprofit, charitable children's residential facility, licensed by the Department of Health, which evidences its desire and capability to provide a service consistent with generally accepted child welfare practices and specific CRC membership criteria.

Membership is achieved and maintained through the use of an intensive peer review evaluation. Membership dues are one third of one percent of an agency's annual expenditures.

CRC has its headquarters in Sacramento and currently employs two full time staff members as well as a governmental affairs consultant.

Benefits from CRC membership include:

1. Access to statistical data and current policies and practices in CRC agencies.

2. Quarterly membership meetings with program content directed to board members, management, and line staff. (e.g. sessions on private income development, evaluation, child care worker training)

3. Current information on legislative and regulatory matters.

4. Interpretation at the state level of the needs of children in residential care.

5. Program consultation through involvement in peer review.

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CRC

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- 65 private nonprofit charitable programs with over 130 separate facilities many of which have been serving children for over fifty years
- Governed by local voluntary boards of directors providing fiscal oversight and community input
- Licensed by the State Department of Health
- Serving 4000 children from the welfare, probation, mental health and developmentally disabled systems
- Providing residential treatment, group homes, foster homes, day treatment and special education

BRIAN F. CAHILL
Executive Director

PEER REVIEW PROCESS

California Association
of
Children's Residential Centers

11th and L Building, 1127 11th Street / Suite 812, Sacramento, California 95814
(916) 446-0241

The Peer Review Process, a benefit of CRC membership, shall be viewed as a continuing means to assist CRC agencies in improving the quality of the programs for the children they serve.

Selection of Review Team

1. The selection of the reviewers shall be a shared responsibility between the Membership Committee and the CRC Executive Director.
2. A review team of no less than two (2) shall be assigned for each review.
3. At least one of the reviewers should be an executive. Middle management may be used when teamed with an executive.
4. The review team must have administrative and program expertise.
5. At least one (1) of the members of the team must be familiar with the type of program to be reviewed.
6. One or both of the members of the team may be from the immediate geographical area of the agency to be reviewed but must not be a "neighbor" to the agency.
7. All potential reviewers must participate in annual mini-conferences for peer review orientation.
8. The reviewers shall be informed in advance of their assignment and shall accept the assignment in writing acknowledging that the whole process and all materials reviewed are held in strict confidence.
9. Board members should be involved as resource consultants where specific problems arise in terms of agency/board relationships.

Agency to be Reviewed

1. The agency to be reviewed shall have the right of approval of the reviewers selected.
2. The agency to be reviewed shall submit the required documentation to the review team ten (10) days prior to the date of the review.

10/5/77

Length and Frequency of Site Visit

1. For smaller agencies, the review will take place in two (2) days.
2. For larger, multi-service agencies, the review will take place in three (3) days. Those program components which relate or refer to 24-hour residential care shall be reviewed.
3. Each agency should be reviewed every 24 to 30 months and within 12 months when there is a change of Executive Director.
4. The Board of Directors can approve a special peer review at any time at their discretion.

Written Report

1. The review team shall follow the outline of the six point Membership Criteria in writing their report. They further shall state in regards to each of the six point membership criteria their recommendations as to Full Compliance, Substantial Conformity or Not Acceptable.
2. A rough draft of the peer review should be completed at the time of the site visit.
3. A preliminary report is to be sent to the CRC Office within fourteen (14) working days following the review. The review team shall collaborate on the preparation of the report to insure continuity in writing style. A cover letter on CRC letterhead should include the names of the reviewers, who they saw at the agency, what they saw and the actual determination for each of the six membership criteria.
4. The preliminary report will be sent from the CRC Office to the agency Executive Director and to the President of the agency board so that both can respond as to factual content. The agency shall return the report to the CRC Office with the corrections within fourteen (14) working days of receipt. If the CRC Office does not receive the report within that time limit, the assumption will be made that there were no corrections.
5. After receiving back any corrected material from the agency Executive or President, the review team shall furnish the final report within forty-five (45) working days from the time of the review to the Association Executive Director.
6. The final draft will go to the Membership Committee and ultimately to the CRC Board of Directors for appropriate action.

Final Process

1. The Association Executive Director makes three (3) copies of the report.

10/3/77

These copies are to be distributed as follows:

a. to the Chairman of the Membership Committee
b. to the Executive Director of the agency reviewed
c. to the Board President of the agency reviewed

2. If the agency disagrees with any part of the report, it shall respond in writing to the Membership Committee within thirty (30) days. In this grievance, it shall include any information necessary to document its objections and if necessary, a conference can be held,if requested by the agency,with the Membership Committee.

3. The Membership Committee reviews the study and ascertains whether an agency is in Substantial Conformity with CRC standards. For full or continuing membership status, the agency shall be in at least Substantial Conformity with everyone of the membership criteria. Any Not Acceptable area must be resolved either through a plan of correction or through probationary status.

4. The Membership Committee may take one of the following actions:

   a. Certify that the agency meets CRC standards and so notify in writing the CRC Board of Directors.

   b. Request additional information from the agency or review team to establish agency conformity.

   c. Send the report to the Board of Directors of CRC, indicating that the agency does not meet CRC standards. Further, the Membership Committee has a responsibility in this report to make a recommendation to the CRC Board of Directors relative to continuing membership in CRC.

5. The CRC Board of Directors may take any one of the following actions:

   a. Notify the Executive and President of the agency that the agency is in conformity.

   b. Review the recommendations of the Membership Committee and request additional information from the Committee survey team and/or agency.

   c. Place the agency not meeting standards on probation with a written recommendation as to required actions by the agency and the period of time given to the agency to come into conformity.

   d. Enlist the technical expertise of legal, accounting, safety or other specialists.

   e. Notify the agency that their membership in CRC is terminated due to the agency not meeting the standards of CRC.

f. At its sole discretion, give notice of the agency's membership status to any or all of the following:

- a. The Membership of CRC
- b. Any licensing or regulatory agency
- c. Any other duly constituted public body

6. One copy of the final peer review report is to be filed in a confidential file in the CRC Office. The report is available to the reviewers of the agency. The peer review report is basically the property of the agency; therefore, they have the right to decide how it should be used and with whom it should be shared. The peer review report is an internal administrative document. If the agency releases the report to others, it must accept full responsibility and liability for the consequences of its release. Reviewers may have access to previous peer review reports.

Membership Committee

1. The Membership Committee is elected annually from the total CRC membership. The term of a member of the Membership Committee is to be two years with four members elected one year and three members elected the succeeding year beginning at the next Annual Meeting. To the degree feasible, no member of the Committee should participate in a peer review. The Chairman of the Committee should be a second year member.

MEMBERSHIP CRITERIA

I. Program

Member agencies shall have stated service and program goals and defined methods of reaching such goals, as related to the needs of the children in care.

II. Organization and Administration

The organization and administrative structure shall provide for clarity of function, accountability, supervision of staff, and protection of the rights of children.

III. Personnel Standards

There will be personnel standards which shall ensure sufficient and qualified staff, employed in an equitable manner, as needed to carry out the agency program goals.

IV. Financial

The agency shall have both the financial resources and systems of fiscal accountability needed to carry out its program and responsibilities, and there shall be clear demonstration of non-profit charitable status.

V. Physical Plant

The facility shall be appropriate to the agency program, maintained in a safe and clear fashion, and shall meet all applicable state and local regulations.

VI. Governing Body

There shall be a governing body which shall define the purpose, goals, and services of the agency and which shall meet regularly to actively fulfill these fiduciary responsibilities.

PEER REVIEW GUIDELINES

Each agency should be reviewed relative to all the guidelines in order to determine if the six membership criteria are met. All significant discrepancies should be identified and noted in the written report. It is expected that CRC membership standards will in some cases exceed licensing regulations.

I. Governing Body

II. Financial

III. Personnel Standards

IV. Organization and Administrative Structure

V. Physical Plant and Equipment

VI. Program

GOVERNING BODY

I. The Governing Body shall be responsive to the needs of the community served by the agency.

   A. It is recommended that the Governing Body have between 15-30 members. Membership shall not be restricted on the basis of sex, age, race or ethnic origin.

   B. No member of the Governing Body shall profit financially by reason of his membership on the governing body nor be employed by the agency regularly either full or part time.

II. Members of the Governing Body shall be elected who have a concern for children and teenagers and have an active interest in their health and welfare.

   A. Members of the Governing Body shall be willing to devote enough time to carry out the duties of the Governing Body.

   B. Shall have a capacity and willingness to interest other members of the community in the work of the agency.

III. There should be a plan for periodic change in membership of the Governing Body. Change should be achieved by an automatic system of rotation and nominating committee responsible for replacing members. Members should attend at least 50% of the regular meetings of the Governing Body.

IV. The Governing Body shall define the purpose, goals and services of the agency and in carrying out these responsibilities shall:

   A. Develop written policies including Articles of Incorporation and By-Laws with periodic review;

   B. Establish and maintain a sound financial structure including proper financial records and audits. An annual budget shall be reviewed and voted on by the Governing Body;

   C. Employ a competent qualified administrator and delegate responsibility for administering the program to that person;

   D. Develop and review periodically, salaries and personnel practices to insure the employment and retention of qualified staff;

   E. Review on a regular basis for performance and adequacy, the program and service goals of the agency.

10/5/77

Governing Body (cont.)

V. The Governing Body shall meet on a regularly scheduled basis, at least quarterly, and shall maintain minutes of all meetings. The chief administrator or his designee shall attend all regular meetings of the Governing Body.

VI. Provision shall be made for the appointment of standing committees and such temporary or special committees as needed.

VII. There shall be a training and orientation program for all new members of the Governing Body.

VIII. The Governing Body shall be protected from suit through errors and omission insurance or other mechanisms of protection.

IX. Community advisory boards should be established where appropriate.

FINANCIAL

I. An accounting system shall be maintained that produces information reflecting the fiscal experience and the current financial position of the agency. Copies of the federal (501(c)(3)) and state (23701d) tax exempt statements, the Registry of Charitable Trusts Report (CT-2), and the Federal 990 Report as well as the State 199 Report shall be available.

II. There shall be a system of accounting that clearly indicates revenue sources and the essential cost elements.

III. Appropriate staff and members of the Governing Body shall develop an annual budget related to the objectives of the agency. This budget shall be approved by the Governing Body.

IV. Program representatives shall meet regularly with agency administrative officers to recommend the personnel, facilities and equipment needed.

V. Monthly reports showing the relationship of the budget to actual experience shall be available for analysis.

VI. An audit of the financial operations of the facility shall be performed by an independent certified public accountant at least annually.

VII. There shall be policies and procedures for the control of accounts for the handling of cash, for credit arrangements and discounts. Also for the management of accounts payable and receivable.

VIII. There shall be an insurance program that provides for the protection of the physical and financial resources of the agency as well as adequate comprehensive liability insurance covering all personnel.

IX. The agency shall have financial resources and a budget that permits it to carry out its responsibilities for children accepted for care.

X. Voluntary sources of support and financing must be obtained through ethical means without jeopardizing the welfare and rights of the children and parents.

XI. All financial dealings between the agency and its staff members shall be at "arms length" distance and shall be based on full disclosure.

PERSONNEL STANDARDS

I. There shall be personnel practices that reflect competent personnel management systems which will enable personnel to function adequately as individuals and as a group and to facilitate the evaluation of personnel in relation to program.

II. There shall be written provision demonstrating the agency's fair employment practices and affirmative action plan.

III. There shall be clearly defined terms of employment, job descriptions, educational experience and personal qualifications required and salary range for each classification.

IV. There should be adequate fringe benefits and competitive salaries to insure the recruitment and retention of qualified staff. Wage and hour provisions of the Fair Labor Standards Act must be met. There should be some indication of the frequency of staff turnover.

V. There shall be provisions for adjudication of employee grievances.

VI. Personnel records shall contain a completed application, references, physical examination including T.B. test, records of disciplinary actions, regular performance evaluations, terms of employment and termination interviews. There shall be procedures for verification of diplomas and licenses. Guidelines should be established regarding who should have access to personnel files.

VII. There shall be provisions for in-service and staff development programs that will orient all employees with the agency's objectives, structure and policies.

   A. Supervision and consultation is to be provided to foster professional growth.

   B. Staff meetings are to be held on a regular basis for discussion of program, problems, policies and methods of practice.

   C. Staff should be encouraged to attend appropriate workshops, classes and institutes.

VIII. There should be policy regarding the use of volunteers including provision for supervision and training.

   A. References are to be checked and an application is to be on file.

   B. Duties, roles, functions, rights and responsibilities are to be clearly identified.

10/5/77

ORGANIZATION AND ADMINISTRATIVE STRUCTURE

I. There shall be evidence that the agency has a valid license to operate as well as evidence of other areas of accreditation, i.e. Joint Commission of the Accreditation of Hospitals, Child Welfare League of America, on-grounds high school accreditation, etc.

II. There shall be a written plan of operation including an organization chart which reflects lines of authority and channels of communication as well as supervisory patterns. There shall be a list of all personnel with their area of responsibilities identified. Ratio of staff to children should be clearly identified.

III. There should be some effort to collect data which reflects the quantity and quality of service. Including any agency research or evaluation programs.

IV. There should be an assessment of community relations and public relations.

V. Children's rights shall be recognized:

A. The staff of the facility shall function in a manner so as to allow an appropriate continuum of privacy for each child/adolescent. The facility's space and furnishings shall be designed and planned to enable the staff to respect the child's/adolescent's right to privacy and at the same time to provide adequate supervision according to the ages and developmental needs to the child/adolescent.

B. Agency policy shall allow visitation with all members of the child's/adolescent's family unless therapeutically contra indicated.

C. Child/adolescent shall be allowed to conduct private telephone conversations with family and friends and to send and receive mail without hinderance. If therapeutic indications necessitate restrictions on visits, calls or other communications, these restrictions shall be evaluated frequently and at least monthly, by responsible administrative or professional staff.

D. The agency shall have written policies and appropriate procedures for receiving and responding to child/adolescent/family comments, questions and/or complaints.

E. The agency shall have written policies regarding methods of control and discipline of child/adolescent which shall be available to all staff, child/adolescent and families.

1. Child/Adolescent shall not discipline other child/adolescent.

Organization and Administrative Structure (cont.)

2. Physical restraint shall require special justification and shall be employed only to protect a child/adolescent from injury to himself or to others and shall not be employed as punishment.

3. When isolation is used, the facility shall have written policies which closely designate the staff members who may authorize its use and the conditions under which it may be used. The child/adolescent in isolation shall be under frequent observation and the use and reason of isolation shall be noted in writing in the child's/adolescent's file. The isolation of a child/adolescent for more than one hour must be specifically authorized by appropriate administrative and/or professional staff.

F. Children's rights need to be posted. Acknowledgement, signed by either the child/adolescent or his representative, must be contained in the child's/adolescent's case record.

G. Guidelines shall be developed regarding the issue of confidentiality of a child's records.

PHYSICAL PLANT AND EQUIPMENT

I. All facilities and equipment shall comply with all applicable federal, state and local building codes and regulations.

II. All facilities shall be maintained in conformity with the regulations adopted by the State Fire Marshall for the prevention of fire and for the protection of life and property against fire and panic.

III. General maintenance and housekeeping: the facility shall be clean, safe, sanitary and in good repair at all times. All units shall be inspected at least weekly and a written report shall be made in regards to safety, repairs and cleanliness. All needed repairs and replacements which constitute a physical danger to staff and/or children shall be corrected immediately.

IV. All vehicles must be kept in a state of good repair.

PROGRAM

I. There shall be a written statement which clearly defines the goals and objectives of the agency. This shall include:

  A. Statement of target population to be served,. ie. intake criteria, age, sex, capacity.

  B. Identification of types of services provided.

  C. Description of treatment philosophy and modalities.

II. There shall be written treatment plans which clearly identify presenting problems, family background, psychodynamics of behavior, treatment objectives and goals, length of stay, etc.

III. There shall be evidence that the staff have the capability of carrying out the treatment goals.

IV. Case records shall include:

  A. Social and legal information

  B. Family History

  C. School Reports

  D. Chronological behavior notes

  E. Incident reports on serious behavior problems, illnesses or injuries

  F. Medical examination, records of immunizations

  G. Authorization for medical care

  H. Placement authorization

  I. Correspondence concerning child

  J. Treatment plan

  K. Progress reports

V. Progress reports shall be submitted to the placing agency on a quarterly basis. Termination reports shall be submitted in a timely manner.

VI. Consultation services used by the agency shall be identified.

VII. There shall be appropriate controls on the use, storage and dispensing of medication.

VIII. There shall be use of community resources to supplement the program resources of the agency.

Program (cont)

IX. Every effort should be made to involve the child's family in the treatment process. Are after care services available?

X. Children should be grouped according to their needs.

XI. Recreational and program opportunities should be made available to each child according to his interests and needs. Identify child's daily routine and schedule. Do children participate in planning?

XII. Children shall be appropriately grouped.

XIII. Staff shall communicate attitudes and feelings to the children which will create a therapeutic and secure environment.

XIV. Children shall be provided with sufficient clothing and items of personnel need.

In Solitary: The Lost Childhood of Joanne W.

Youth Panel Probes Juvenile Confinement

By Donnie Radcliffe
and Jacqueline Trescott

On the walls were black and white blow-ups of children—one looking through prison bars, another huddled in a prison cell, and a third stretching his arms out through the cell peephole. At a table in front of the photographs sat five children, all reporters from the Children's Express, a New York-based publication, who convened in Washington for three days of hearings on incarcerated children.

A few feet away, sitting at the green-felt-draped witness table and facing a battery of television cameras, was Joanne W., a 21-year-old Illinois woman who as a child had been institutionalized for seven years. She was testifying about her first-hand experiences in foster homes, a mental hospital and reform school, but particularly her 58 days in solitary confinement. Joanne W. twice was tied onto a bed and severely drugged.

"What did you lose in life from being incarcerated?" asked Robin Moulds, a 13-year-old student at New York's exclusive Chapin School, and the moderator of the hearings. "I lost out on my whole childhood and never going to a regular school," said Joanne W., her voice never changing from a matter-of-fact monotone.

Though the adolescent questioners and the witnesses came from different ends of the American experience, their youth provided them some common ground in understanding the situations of the 100,000 children who are estimated to inhabit public institutions on any given day in the United States.

"How would you define an institution?" Moulds asked Joanne W. "It's a place to throw away people they don't want to bother with anymore," was the reply.

During the questioning Moulds appeared impassive, and later she explained that she was aiming for a judge-like posture. "But at times I have felt like crying. It hurt that I could be part of a society that could do these things, the horrors of solitary confinement, the forced drugs," said Moulds.

Her Park Avenue background (and the representatives of Children's Ex-

See CHILDREN, B14, Col. 1

In Solitary: The Lost Childhood of Joanne W.

CHILDREN, From B1

press ranged from low-income to the upper-class) didn't create a distance with the witnesses, she added. "I don't think we have ever thought of being different. We are all kids, just the feeling of being alone, being isolated in solitary, is something every teenager has felt."

One adult witness testified that in a 30-state survey of juvenile penal institutions, he found "some form of punitive isolation was used for children who break rules or otherwise cause problems." The practice, he says, often hides behind such euphemisms as "Quiet Room," "Meditation," "Time Out," "Restraints."

At times during the testimony, now in its third day at the downtown storefront headquarters of Day Care and Child Development Council of America, grasps were heard from the spectators, some of them vacationing schoolchildren.

Joanne W. is not her real name but it is the one she prefers to use. She is overweight, her smile tentative. She also is strong-minded and gifted, and as a child tested out with an intelligence quotient of 140.

Her mother was single, sometimes on public aid, sometimes doing clerical work, and aware of Joanne's potential. Advised by social workers that if Joanne were made a ward of the juvenile court she would be sent to a boarding school and given proper education, the mother agreed.

But it never quite worked out that way. After two days in boarding school—"the only black face in a sea of white faces," says her lawyer—she was called unruly, shipped off on a melancholy seven-year odyssey of foster homes, detention homes, a mental institution and a training school.

"The first time I was tied up, the first time was when they titled me as a bully," Joanne W. recalled.

Toward the end of her detention, she came to the attention of a Chicago attorney with the Legal Aid Society, Patrick Murphy, who used the civil rights laws to sue the Illinois Departments of Mental Health and Children and Family Services for unwarranted and excessive treatment of Joanne W. in her 58 days of solitary confinement.

Kenneth P. Wooden, executive director of the National Coalition for Children's Justice, describes "typical" conditions of solitary confinement: "The rooms are dirty, damp, vermin-infested and vile-smelling."

He says forced, isolated confinement can, upon occasion, have a devastating effect on the mind and body, impairing vision, coordination and hearing.

Joanne W.'s case was initially thrown out by the lower court but on appeal the higher court ruled the contary. The state settled out of court, giving Joanne W. $25,000. "Joanne came out of it pretty well," said Murphy. "She's bright, strong, with tremendous potential. There are worse cases, believe me."

"I guess," says Joanne W. "that I miss most the childhood I never had. If I can do something to help others like me, well, maybe that's good."

Every penny of Joanne W.'s $25,000 is gone today, spent by her in a yearlong spree of going places (California three times) and buying things (a jukebox, a pinball machine, a stereo set, some glass dishes) she had never had a chance to own before.

The White House already has announced a national conference on children to be held here next year in the context of the Year of the Child.

That's one of the reasons Children's Express (which scooped everybody at the 1976 Democratic National Convention by reporting Walter Mondale's selection as vice president) has been investigating runaways, abused children, the children of alcoholic parents and victims of incest.

This week's hearings were called to inform the public, and hopefully influence state legislatures and national politicians, to change laws that permit solitary confinement. They were patterened after regular congressional hearings, with witnesses bringing films, drawings of prison cells and statistics. But it was the fact that they were convened by children (guided by Kenneth Wooden) that attracted the major media, including a live telecast by WETA (Channel 26) as well as congressional interest. Sen. George McGovern (D-S.D.) is scheduled to speak at this morning's concluding hearings.

Joanne W. said she spent a long period of solitary confinement, tied to a bed in spread-eagle fashion, after she struck an attendant.

"They tied me up and administered shots (Thorazine), and I was in restraints that time for about 30 days," she said, as the questioners took notes and watched the impassive look on her face.

What was it like? asked one.

"It became a matter of life. Sometimes I would have dreams and pretend I was somewhere else," Joanne W. replied. "It wasn't fantasy. It [illegible] occupied my time."

CHILD ABUSE AND NEGLECT

Reports

INSTITUTIONAL ABUSE AND NEGLECT: AN UPDATE

by

John P. Corrigan, Program Analyst, NCCAN

SENATE HEARINGS HELD

Senator Alan Cranston, Chairman of the Senate Human Resources Subcommittee on Child and Human Development, held hearings in Washington, D.C. on January 24, 1979, probing what he called, "the abuse of hundreds -- perhaps thousands of children -- living in government sponsored and private institutions."

Cranston's Subcommittee had learned that, "some institutions for handicapped, abandoned or delinquent children are apparently providing abysmal living conditions for children in return for millions of dollars in Federal support". Senator Cranston stated that, "despite the repeated stories of incidents of brutal treatment of children in some of these homes, there does not appear to have been any systematic examination of the scope of the problem on a national basis".

The purpose of the hearings was to gather specific information on the extent of the problem and to develop alternatives for dealing with abuse and neglect of children residing in institutions or other group settings.

Witnesses at the first day of the Subcommittee's hearings -- held on January 4, 1979, in San Francisco -- presented very troubling testimony about the scope and dimensions of this problem and the shocking conditions in some institutions housing children. Abuses reported to the Subcommittee included pinching, slapping, jabbing pencils between the children's fingers, cold showers, confinement to cubicles or closets, withholding of food as punishment, forcefeeding, pinching of genitals, and the use of electric cattle prods as a form of "treatment".

Representatives from HEW's Office of Human Development Services and the Civil Rights Division of the Justice Department appeared as witnesses at the January 24th hearing in Washington. The Honorable Arabella Martinez, Assistant Secretary for Human Development Services, testified for DHEW, and Assistant Attorney General Drew S. Days provided testimony for the Civil Rights Division. Agency representatives were asked to speak to three areas: (1) what activities they are currently carrying out in the area of institutional abuse of children, (2) what additional steps they feel would be appropriate, and (3) their plans to take such actions. Testimony was also provided by witnesses from the four government agencies (New Jersey, Utah, District of Columbia, and Massachusetts) which received HEW grants in September, 1978, in the area of investigation and correction of child abuse and neglect in residential institutions.

Assistant Secretary Martinez, in her opening remarks, stated that the hearings were testimony to a growing public concern for the 360,000 children who live in residential institutions, temporary and long-term shelters, detention centers and homes, centers for the mentally retarded and developmentally disabled, and group homes; and for the 394,000 children who have been placed in foster family care. The Assistant Secretary noted that these figures represent approximately one percent of the U.S. child population. Her remarks addressed only child abuse and neglect which occurs in residential institutions and not maltreatment in schools, daycare centers, recreation programs or other nonresidential settings. Highlights of her statement included:

PRESENT KNOWLEDGE ABOUT INSTITUTIONAL CHILD ABUSE AND NEGLECT:

Our knowledge about the actual extent or the exact nature of institutional child abuse and neglect in the United States is abysmally minimal. To a large degree this is so because the administrative, regulatory and proprietarial systems which have charge of such institutions are generally within the control of the States. Yet we have only meager data on the nature, incidence and severity of such residential child abuse and neglect, and no definitive statistics. For example, the validated reports collected by the American Humane Association for 1977 included 81 reports from 26 States involving employees of residential institutions.

Nevertheless, from this limited information, and based on the specific instances that have come to our attention, we are led to suspect that we are only learning about a very small portion of the problem and, in fact, we are only seeing the tip of the iceberg.

HEW ACTIVITIES TO PREVENT INSTITUTIONAL CHILD ABUSE AND NEGLECT:

The Child Abuse, Prevention, and Treatment Act of 1974, which created the National Center on Child Abuse and Neglect (NCCAN), gave the Federal government responsibility primarily for the prevention and treatment of abuse within the family. The responsibility of NCCAN does extend to institutional abuse. Its role is one of technical assistance and active encouragement to the States in the areas of prevention, identification, and the remediation of child abuse and neglect in residential institutions.

In fulfilling its responsibilities toward institutionalized children, NCCAN has focused on four primary areas:

- reporting, investigation, and correction procedures
- model State legislation
- co-sponsorship of a national conference on institutional abuse of children
- demonstration grants on investigation and correction of institutional abuse.

REPORTING, INVESTIGATION, AND CORRECTIVE PROCEDURES:

One requirement for eligibility for State grants is that the State must develop procedures, with the force of State law or administrative regulation, to handle the receipt of reports of known or suspected institutional child abuse and neglect, its investigation and correction.

In Fiscal Year 1978, a total of 47 States, including the District of Columbia, the Commonwealth of Puerto Rico and the Territories, had attained full or conditional eligibility for State grants, and we expect that number to reach 50 during Fiscal Year 1979. To meet the eligibility requirements as they affect institutional child maltreatment, States have vested investigative authority in various agencies.

MODEL STATE LEGISLATION

To assist States in developing their own child abuse and neglect legislation, NCCAN developed a Draft Model Child Protection Act. This was widely distributed for comment to policy-makers and professionals in the field. This Act includes a section that specifically addresses institutional child maltreatment. That section incorporates requirements for: (1) designation of an independent investigative agency; (2) an official agreement containing procedures for receiving reports, making investigations and taking remedial action; and (3) a means of incorporating information on the progress, findings and dispositions of investigations into the State's central child protection system. In addition, the Act provides for purchase of service agreements between a State's mandated child protection agency and another public or private agency to serve as the officially designated investigative authority in residential cases.

NATIONAL CONFERENCE ON INSTITUTIONAL ABUSE:

In June, 1977, NCCAN co-sponsored, with its Region II Resource Center at Cornell University, a pioneering National Conference on the Institutional Maltreatment of Children. Major areas of concern identified by Conference participants included: the large size of institutions, inadequate staffing, isolation from community and family; need for public awareness; need for expanded regulation of residential institutions; need for appropriate alternatives and support services to reduce unnecessary institutionalization.

Recommendations that emerged from the Conference have been and will continue to be useful in shaping NCCAN policy. One result has been the development of specific standards addressing institutional abuse which were included in the "Draft Federal Standards for Child Abuse and Neglect Prevention and Treatment Programs and Projects". These draft standards were distributed for review and comment by the field in March, 1978, and are currently being used in program development.

DEMONSTRATION GRANTS:

In September, 1978, NCCAN awarded four demonstration grants on the "Investigation and Correction of Child Abuse and Neglect in Residential Institutions". Eligibility for these grants was limited to State agencies with legal authority to make investigations and take corrective action. The grantees were chosen by a non-Federal peer review panel.

The grantees are the Utah Division of Family Services, the Massachusetts Office for Children, the District of Columbia Social Rehabilitation Administration, and the New Jersey Division of Youth and Family Services. Each received approximately $80,000 a year for a project period extending three years. These demonstration projects will develop procedures for making practical use of the goals embodied in child abuse legislation.

OTHER RELATED NEW ACTIVITIES

- The President's Committee on Mental Retardation (PCMR) has drafted a report on the prevention and treatment of child abuse and neglect in institutions for the mentally retarded. This report incorporates material contained in the Draft Federal Standards for Child Abuse and Neglect Prevention and Treatment Programs and Projects. PCMR is now planning site visits to institutions in order to focus on accrediting policies, on methods of behavioral control, and on the use (or misuse) of medication. Findings from these visits and the draft report will form a basis for recommendations on how to reduce abuse in institutions for the mentally retarded.
- The Developmental Disabilities Program (DDP) over the past eight years has provided funding for a contract which developed standards for residential facilities and for the development of training programs in the use of these standards. A training program utilizing these standards is provided by the contractor to institutions for a modest fee. More than 100 workshops in 35 States have been held since 1975.
- In addition, since the fall of 1977, the DDP has assisted States in creating Protection and Advocacy programs. Several States have used their own funds to supplement the Federal funds and have created programs focusing specifically upon residential institutions. New Jersey, Illinois, and Michigan have developed programs of residential advocates who work with the State institutions. Delaware, Indiana and New York are currently organizing their own institutional protection and advocacy systems.

- The Children's Bureau has supported the development and use of curricula for the training of residential child caregivers and foster parents.

- The Runaway Youth Program, administered by the Youth Development Bureau, provides services for young people who have run away from institutions as well as from their own homes. The program works to correct the conditions affecting the young people who come to the shelters it funds.

- The program being developed as a result of the 1978 Adoption Opportunities Act (P.L. 95-266, Title II) will assist in alleviating potential abuse of children in institutions by enabling permanent placements to be increased. The model act, the data gathering system, the adoption information exchange and the training and technical assistance activities will provide direction to State and local governments and agencies to aid them in increasing opportunities for adoption.

- Under the Medicaid Program, several requirements have a bearing on child abuse detection and prevention:

  Institutions receiving Medicaid or Medicare payments for long-term care must have in place a "Patient Bill of Rights" which specifically provides that each patient shall be free from mental and physical abuse, and free from chemical and physical restraints, except under certain limited conditions.

  Institutions are also subject to medical and professional review requirements under which a team of health professionals annually review each patient's care. In addition, each institution is reviewed annually to ensure that it meets certification standards. These reviews provide an opportunity to detect abuse of the patient.

In closing her testimony, Assistant Secretary Martinez asserted that this administration has consistently encouraged each State to furnish services directed at the goals of (1) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; (2) securing referral or admission for institutional care when other forms of care are not appropriate; (3) providing services to individuals in institutions. This includes expenditures for administration (including planning and evaluation), and personnel training and retraining directly related to the provision of those services.

The Administration is proposing several different ways to reduce the abuse and neglect of children in institutions:

- The enactment of this year's Child Welfare Amendments, designed to improve the foster care and child welfare systems by requiring protections for children in care, such as case reviews and hearings on the status of their placements. The proposal also stresses the need for permanent placement of children, either through services designed to return them to their families, or through a program of subsidized adoption for children with special needs.

- Upgrading and strengthening of States' licensing programs through active assistance of the Children's Bureau by publication of materials such as, "Licensing - Interaction between the Licensing Agent and Service Providers", (Copies may be obtained by writing to Mr. Jake Terpstra, Licensing Specialist, U.S. Children's Bureau, Washington, D.C. 20201 and requesting Publication No. (OHDS) 78-30119); provision of technical assistance by Children's Bureau staff to individual States; the inclusion of training for State licensing staff as a priority in awarding grants under the Child Welfare Services Training Program; and the development of licensing materials for State use including a model licensing law; guideline licensing requirements for child placing agencies, child care institutions, and foster family homes; and describing the key elements in an effective licensing operation.

DEPARTMENT OF JUSTICE TESTIMONY

The Honorable Drew Days of the Department of Justice noted in his opening remarks that the Department has, "since 1971, been involved as an intervenor or litigating amicus curiae in a number of cases concerning the constitutional rights of confined persons, and in several of those cases there has been substantial evidence of abuse of children, as defined in the legislation which is the subject of these hearings". Senator Cranston and Mr. Days also noted, that legislation was under consideration during the prior Congress, and has been introduced in the 97th Congress, to give the Attorney General explicit authority to institute suits against particular classes of institutions where he has reasonable grounds to believe that persons are being deprived of their constitutional rights. Reference was made to S. 10 and H.R. 10 which were introduced on January 15, 1979. Two reasons were put forth underscoring the need for authorizing legislation. First, the experience of the Department in prior related litigation has demonstrated that basic constitutional and Federal statutory rights of persons confined in institutions are being violated on such a systematic and wide spread basis to warrant the attention of the Federal government. Secondly, some courts have held that the Federal government lacks the power to bring such suits absent authorization from Congress.*/ One court has even suggested that the United States lacks the requisite standing to intervene in an on-going private suit.**/

In conclusion, Mr. Day expressed these compelling remarks: "Children in institutions are peculiarly unable to articulate their rights and to use the courts to redress deprivations of those rights. It is unfortunate that resort to the legal system has been increasingly necessary to secure the basic rights for institutionalized persons to which all citizens are entitled.

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*/ United States v. Solomon, 419 F. Supp. 358 (D. Md. 1976), aff'd, 563 F. 2d 1121 (4th Cir. 1977); United States v. Mattson, No. CV74-138-BU (D. Mont.) appeal argued November 8 1978, No. 76-3568 (9th Cir.).

**/ Alexander v. Hall, C.A. No. 72-209 (D. S.C.), order of June 16, 1978.

However, while that forum is needed, I believe that the United States, through the Attorney General, can be an effective advocate for those unable to speak for themselves, and I hope that Congress will enact legislation within the next few months which will provide a firm basis for fulfilling the commitment of the United States to constitutional treatment of all institutionalized persons".

HEARINGS' CONCLUSIONS

Senator Cranston declared that the Subcommittee will be pressing forward on four fronts regarding the national problem of abuse and neglect of children residing in institutions or group settings: first, pursuing oversight activities through future hearings; second, actively seeking to enact adoption and foster care reform legislation; third, pushing for enactment of S. 10; and fourth, monitoring HEW's activities pursuant to the Child Abuse Prevention and Treatment Act.

NCCAN INSTITUTIONAL ABUSE GRANTEES HOLD FIRST MEETING

Four National Centers on Child Abuse and Neglect (NCCAN) grantees funded for "Investigation and Correction of Child Abuse and Neglect in Residential Institutions" held their first meeting in Washington, D.C. on January 23-25, 1979. The purpose of the meeting was to establish project linkage and share program goals, objectives, and expectations. Representing the grantees were: Sharon Harrell (District of Columbia), Dr. Donald Kline and Dr. Samuel London (Utah), Gregory Smiles (New Jersey) and Lawrence Aber and Gerald Goldman (Massachusetts). Participants also included staff of the President's Committee on Mental Retardation, the Interstate Consortium on Children's Residential Case Facilities, and other Federal agencies.

Discussions ranged from project descriptions, status of implementation, problems encountered in start-up and corrective actions, staffing, and project and NCCAN evaluation and reporting requirements.

A synopsis of each grantee's presentation follows:

- Utah's project is conducting a comprehensive computer search of the relevant professional literature; generating demographic, attitudinal, psychological, and socioeconomic profiles of staff and residents of all types of residential institutions; and employing "participant observers" for monitoring behavior and gathering observational data about the types of interactions between and among staff and residents. Future plans include the development and implementation of treatment methods; establishment of multidisciplinary Correction Action Teams for each institution; and development and validation of a system for reporting known and suspected cases of institutional abuse to an independent investigative agency.

- Massachusetts' project is creating substate regional visitation-review committees and a statewide task force to address primary prevention;

refining licensing and standard setting functions for the residential placement of children, and refining the mechanisms worked out with the State Department of Welfare for receiving reports and investigating and correcting individual cases.

- The District of Columbia's project is initiating a system for allowing residents in the institution to report maltreatment by signing their names to a form and depositing it directly into locked boxes which will be checked daily. These reports, together with staff-initiated "unusual incident reports", will begin an investigative and corrective process that will involve independent investigators, a review panel which will include residents and outside advocates and make recommendations to the Administrator of the Social Rehabilitation Administration. In addition, the project will provide Advanced Counselling Groups for staff to aid them in dealing with staff-child confrontations and problems of discipline.

- New Jersey's project is examining and testing three different approaches to advocacy and procedures, using internal, State administered, and private citizen advocacy systems of investigation. It will also make a major effort at raising awareness of institutional employees of their responsibility to report known and suspected cases of child maltreatment.

Also participating in this meeting at the invitation of NCCAN were: Larry King, Director, Four County Advocacy Program, Owings Mill, Maryland Jerome Miller, Ph.D., Director, National Center for Action on Institutions and Alternatives, Washington, D.C., and George Thomas, Ph.D., Director, NCCAN Region IV Resource Center, Athens, Georgia. They provided insight, perspectives, and expert commentary regarding the problem of maltreatment of children in residential settings especially as it could relate to the endeavors of NCCAN and its grantees.

INSTITUTIONAL ABUSE TO RECEIVE EMPHASIS AT NATIONAL CONFERENCE

The subject of child abuse in residential institutions will receive increased emphasis at this year's Fourth National Conference on Child Abuse and Neglect, to be held in Los Angeles, October 7-10, 1979.

Plans are being formulated to have a major session on institutional abuse, followed by a number of workshops on various aspects of the problem. The proposed major session will develop a model for understanding institutional abuse, including its similarities to and differences from abuse in the context of a child's own family. The model will seek to illustrate the points at which it is most possible to prevent or take timely corrective action in cases of institutional abuse.

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Public Law 93-247
93rd Congress, S. 1191
January 31, 1974

An Act

To provide financial assistance for a demonstration program for the prevention, identification, and treatment of child abuse and neglect, to establish a National Center on Child Abuse and Neglect, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Child Abuse Prevention and Treatment Act".

Child Abuse Prevention and Treatment Act.
88 STAT. 4
88 STAT. 5

THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

Establishment.

SEC. 2. (a) The Secretary of Health, Education, and Welfare (hereinafter referred to in this Act as the "Secretary") shall establish an office to be known as the National Center on Child Abuse and Neglect (hereinafter referred to in this Act as the "Center").

(b) The Secretary, through the Center, shall—

(1) compile, analyze, and publish a summary annually of recently conducted and currently conducted research on child abuse and neglect;

Annual research summary.

(2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of child abuse and neglect;

Information clearinghouse.

(3) compile and publish training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect;

(4) provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect;

(5) conduct research into the causes of child abuse and neglect, and into the prevention, identification, and treatment thereof; and

(6) make a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity.

Study.

DEFINITION

SEC. 3. For purposes of this Act the term "child abuse and neglect" means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary.

DEMONSTRATION PROGRAMS AND PROJECTS

Grants and contracts.

SEC. 4. (a) The Secretary, through the Center, is authorized to make grants to, and enter into contracts with, public agencies or nonprofit private organizations (or combinations thereof) for demonstration programs and projects designed to prevent, identify, and treat child abuse and neglect. Grants or contracts under this subsection may be—

(1) for the development and establishment of training programs for professional and paraprofessional personnel in the fields of medicine, law, education, social work, and other relevant

code of federal regulations

45

Public Welfare

PART 500 TO END

Revised as of October 1, 1977

CONTAINING
A CODIFICATION OF DOCUMENTS
OF GENERAL APPLICABILITY
AND FUTURE EFFECT
AS OF OCTOBER 1, 1977

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CONGRESSIONAL RESEARCH SERVICE
JUL 27 1978

PART 1340—CHILD ABUSE AND NEGLECT PREVENTION AND TREATMENT PROGRAM

Subpart A—General Provisions

Sec.
1340.1-1 Purpose of the program.
1340.1-2 Definitions.
1340.1-3 General administrative requirements.
1340.1-4 Application for a grant.
1340.1-5 Awards.
1340.1-6 Conflict of interest.
1340.1-7 Non-allowable costs.
1340.1-8 Grant appeals.
1340.1-9 Civil rights.
1340.1-10 Non-discrimination of handicapped.
1340.1-11 Project duration.
1340.1-12 Program and project plan amendments.
1340.1-13 Protection of human subjects.
1340.1-14 Publications and copyright policy.
1340.1-15 Reports.

Subpart B—Demonstrations, Technical Assistance, and Other Activities

1340.2-1 Demonstrations.
1340.2-2 Technical assistance.
1340.2-3 Training materials and training.
1340.2-4 Research.
1340.2-5 Confidential information.

Subpart C—Child Abuse and Neglect Grants to States Under the Act and Under Title IV of the Social Security Act

1340.3-1 Purpose and eligible applicants.
1340.3-2 Establishment of compliance.
1340.3-3 Qualification for assistance.
1340.3-4 Approval of compliance statements and plan amendments.
1340.3-5 Approval of applications, plan amendments, and funds.
1340.3-6 Funds available.
1340.3-7 Allocation of funds available.
1340.3-8 Reallocation of funds available.

Subpart D—Coordination of Federal Programs and Activities Related to Child Abuse and Neglect

1340.4-1 Purposes.
1340.4-2 Definitions.
1340.4-3 Reports and Materials.
1340.4-4 Coordination Process.

AUTHORITY: Secs. 2-5 and 7, Pub. L. 93-247, 88 Stat. 4, as amended by Sec. 8(d), Pub. L. 93-644, 88 Stat. 2310 (42 U.S.C. 5101-5103).

SOURCE: 39 FR 43937, Dec. 19, 1974, unless otherwise noted.

Subpart A—General

§ 1340.1-1 Purpose of the program.

(a) The basic purpose of this program is to assist States and localities, and nonprofit private organizations in carrying out their responsibilities for the protection of children and for the amelioration of their environment, particularly as an integral part of a family unit whose adult member(s) need help in coping with emotional or environmental stresses.

(b) The main thrust of this program effort is to assist State, local, and voluntary agencies and organizations to strengthen their capacities to develop programs that will:

(1) Prevent child abuse and neglect;

(2) Identify abused and neglected children; and

(3) Provide necessary ameliorative services to them and their families.

(c) In order to achieve this purpose, the National Center on Child Abuse and Neglect will:

(1) Develop, gather, analyze, and disseminate information on child abuse and neglect research, public and private programs, training materials, and the national incidence of child abuse and neglect;

(2) Provide technical assistance to public agencies and nonprofit private organizations to assist them in their activities relating to the prevention, identification, and treatment of child abuse and neglect;

(3) Conduct research in order to develop new techniques in identifying, preventing, and treating child abuse and neglect; and

(4) Make grants and enter into contracts for demonstrations and program models designed to develop and establish improved training programs, more effective service delivery vehicles, and for other innovative programs and projects showing promise of successfully preventing or treating child abuse and neglect.

(d) In seeking to directly assist and encourage States to improve their capacity to identify, prevent, and treat child abuse and neglect, the Secretary will:

(1) Provide Federal financial assistance under the Act to States meeting the requirements therefore; such assistance is designed to enable States to develop, strengthen, and carry out activities related to child abuse and neglect, and

(2) Require the single State agencies to meet specified requirements in order to receive assistance for activities related to child abuse and neglect assisted under Part A or B of Title IV of the Social Security Act.

§ 1340.1-2 Definitions.

For purposes of this part—

(a) "Act" means the Child Abuse Prevention and Treatment Act, 88 Stat. 4 (Pub. L. 93-247), unless otherwise specified.

(b) "Child abuse and neglect" means harm or threatened harm to a child's health or welfare by a person responsible for the child's health or welfare.

(1) "Harm or threatened harm to a child's health or welfare" can occur through: Non-accidental physical or mental injury; sexual abuse, as defined by State law; or negligent treatment or maltreatment, including the failure to provide adequate food, clothing, or shelter. *Provided*, However, that a parent or guardian legitimately practicing his religious beliefs who thereby does not provide specified medical treatment for a child, for that reason alone shall not be considered a negligent parent or guardian; *However*, such an exception shall not preclude a court from ordering that medical services be provided to the child, where his health requires it.

(2) "Child" means a person under the age of eighteen.

(3) "A person responsible for a child's health or welfare" includes the child's parent, guardian, or other person responsible for the child's health or welfare, whether in the same home as the child, a relative's home, a foster care home, or a residential institution.

(c) "Director" means the Director of the Office of Child Development.

(d) (1) "Facility" means a building or portion thereof used to house programs or services designed to treat or prevent child abuse and neglect such as attention homes; emergency shelters; nurseries or treatment rooms or wards; central reporting registers; hot line services; diagnostic treatment and training centers; hospital emergency rooms and neighborhood health centers; and other services or programs established to deal with the prevention and treatment of child abuse and neglect.

(2) "Repair or minor remodeling or alteration of an existing facility" means the physical modification of the facility, the cost of which must be reasonable in relation to the total proposed cost of the program or project and is consistent with the provisions of Chapter I-44 of the Grants Administration Manual of the Department of Health, Education, and Welfare.

(e) "Non-profit private organization" means a corporation or association, the income of which is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1954.

(f) "Project period" means the total period of time for which a project is approved for support with Federal funds.

(g) "Secretary" means the Secretary of the Department of Health, Education, and Welfare.

(h) 'State' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, American Samoa, the Virgin Islands, Guam and the Trust Territory of the Pacific.

(i) "The single State agency" means the State agency administering or supervising the administration of the State plan under title IV-A and IV-B of the Social Security Act.

(j) As used in this part, words importing the masculine gender may be applied to female persons or organizations.

[39 FR 43937, Dec. 19, 1974, as amended at 41 FR 53663, Dec. 8, 1976]

§ 1340.1-3 General administrative requirements.

(a) The provisions of Part 74, Administration of Grants, of this title shall apply to all grants made under this part.

(b) Any contract under this part shall be entered into in accordance with and shall conform to all applicable laws, regulations, and other published Departmental policy.

[39 FR 43937, Dec. 19, 1974, as amended at 41 FR 53663, Dec. 8, 1976]

§ 1340.1-4 Application for a grant.

(a) An application for a grant under this part shall be submitted by such time and in such form and manner as the Director may prescribe. The application shall contain a budget and narrative plan of the manner in which the applicant intends to conduct the project and carry out the applicable requirements of this part.

(b) The application must be signed by an individual authorized to act for the applicant and to assume for the applicant the obligations imposed by the statute, the applicable regulations of this part, and any additional conditions of the grant.

§ 1340.1-5 Awards.

All grant awards and contract awards for programs or projects under the Act shall be in writing and shall constitute the encumbrance of the Federal funds awarded. An award shall specify the project period.

§ 1340.1-6 Conflict of interest.

Employees or individuals participating in a program or project under the Act shall not use their positions for a purpose that is, or gives the appearance of being motivated by a desire for private gain for themselves, or others, particularly those with whom they have family, business or other ties.

§ 1340.1-7 Non-allowable costs.

(a) Federal financial assistance is not available under the Act for the construction of facilities.

(b) No Federal financial assistance may be furnished under the Act for the cost of activities for which payment is made under another part of this chapter or under other authority for the same purpose.

§ 1340.1-8 Grant appeals.

When a post-award dispute arises in the administration of grants under the Act following certain determinations adverse to a grantee, the grantee may apply for a review of such determination in accordance with the provisions of Subtitle A, Part 16, of this title.

§ 1340.1-9 Civil rights.

Attention is called to the requirements of title VI of the Civil Rights Act of 1964 (78 Stat. 252 (42 U.S.C. 2000d et seq.)) and in particular section 601 of such act, which provides that no person in the United States shall, on the grounds of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. A regulation implementing such title VI, which applies to grants and contracts made under this part, has been issued by the Secretary of Health, Education, and Welfare with the approval of the President (45 CFR Part 80).

§ 1340.1-10 Non-discrimination of handicapped.

No otherwise qualified handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in any program, project, or activity assisted under the Act. No otherwise qualified individual shall be denied employment in any program, project, or activity assisted under this part solely because of a physical or mental disability (Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794)).

§ 1340.1-11 Project duration.

Programs and projects may be approved for a period not to exceed five years. Program and project budgets must be submitted and will be reviewed and approved annually.

§ 1340.1-12 Program and project plan amendments.

(a) The grantee shall submit an amendment describing any material change in the plan of his program or project proposed to be made during the project period. Proposed program or project plan amendments shall be submitted in writing for appropriate review prior to consideration by the Director.

(b) Proposed program and project plan amendments may be initiated by the Director if, on the basis of reports, it appears that Federal funds are being used for purposes beyond the scope of the approved project application.

§ 1340.1-13 Protection of human subjects.

The provisions of Part 46 of Subtitle A of this title, the Protection of Human Subjects, shall apply to all grants and contracts assisted under the Act supporting research, development, and related activities in which human subjects at risk, as defined in 45 CFR Subtitle A, § 46.3(b), are involved.

§ 1340.1-14 Publications and copyright policy.

(a) The results of any activity supported under this part may be published without prior review by the Department: *Provided*, That such publication's preface shall acknowledge the Federal assistance received and stating that interpretations of data do not necessarily represent interpretations of the Department and *Provided, further*, That 35 copies of such publication are furnished to the Department.

(b) Where a project activity leads to the publication of a book or other copyrighted material, the author is free to copyright the work, but the Department reserves royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use, and to authorize others to use all copyrightable or copyrighted material resulting from the grant-supported activity. Any such publication shall contain a notice of such license.

§ 1340.1-15 Reports.

Reports shall be made to the Director in such form and containing such information as the Director may find necessary to enable the Director to perform his functions under this part.

Subpart B—Demonstrations, Technical Assistance, and Other Activities

§ 1340.2-1 Demonstrations.

(a) *Eligible applicants or contractors.* The Director will make grants to or enter into contracts with public agencies or nonprofit private organizations (or combinations thereof) for demonstration programs and projects.

(b) *Nature of demonstration programs and projects.* (1) Such demonstrations may include, but are not limited to pilot or experimental efforts to provide additional and more effective ways of preventing, identifying or treating child abuse and neglect than are currently available; testing the feasibility of providing child abuse and neglect services in new settings or under new conditions; innovative programs and methods of providing preventive and treatment services in urban and in rural areas; methods of coordinating most effectively the variety of disciplines and agencies involved in child abuse and neglect; the establishment and maintenance of facilities, such as central registers, satellite centers, attention homes, emergency shelters, hospital emergency rooms, neighborhood health centers, and "hot lines"; provision of consultation by teams to small communities; programs for the prevention and treatment of child abuse related to drug abuse; and, parent self-help projects and programs.

(2) All such demonstrations shall be evaluated, either as a part of the program or project or through a separate contractual effort. All demonstration programs should include provisions for continuing the program within the agency or organization or under other auspices upon the termination of funding under the Act. These provisions should be reasonable and firm commitments rather than hopeful expectations.

(c) *Manner of solicitations.* (1) Grant applications will be solicited through Program Announcements specifying the project goals and objectives for which applications are being solicited, the criteria by which they will be judged, the amount of funds available for such grants, and the deadline for receipt of applications.

(2) Contracts will be awarded in accordance with the procurement regulations of the Department of Health, Education, and Welfare (41 CFR Subtitle A, Part 3).

(d) *Per centum of appropriation.* Not less than 50 per centum of the funds appropriated under the Act for any fiscal year shall be used for carrying out the provisions of subsection 4(a) of the Act.

(e) *Special criterion for selection—equitable distribution.* (1) The formula prescribed in § 1340.3-7, which includes for each State a minimum amount and an additional amount based on the number of children under the age of eighteen, is designed to achieve equitable distribution of assistance among the States.

(2) In the selection of applications submitted under this subpart which are judged to be of approximately equal merit, the Director will take into account the extent to which the selection of one applicant as against the other may achieve equitable distribution of assistance among geographic areas of the Nation and among rural and urban areas.

§ 1340.2-2 Technical assistance.

Technical assistance authorized in subsection 2(b)(4) of the Act will be furnished by the National Center on Child Abuse and Neglect directly, by grant, or by contract, to public agencies and nonprofit private organizations to assist them in planning, improving, developing and carry out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect.

[41 FR 53663, Dec. 8, 1976]

§ 1340.2-3 Training materials and training.

The National Center on Child Abuse and Neglect, directly, through grants, or through contracts, will develop, compile and publish training materials and conduct training for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect.

[41 FR 53663, Dec. 8, 1976]

§ 1340.2-4 Research.

The National Center on Child Abuse and Neglect will conduct research into the causes of child abuse and neglect and into the prevention, identification, and treatment thereof. Such research will include a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity.

§ 1340.2-5 Confidential information.

(a) All information including lists of names, addresses, photographs and records of evaluation, obtained as to personal facts about individuals served by any demonstration, research, training or technical assistance project or program assisted under the Act shall be held to be confidential and may not be disclosed except as provided in paragraph (b).

(b) The use of such information and records shall be limited to purposes directly connected with the administration of the program or project, including evaluations thereof conducted under contract from the Department of Health, Education, and Welfare, and such information may not be disclosed, directly or indirectly, other than for such a purpose thereof or pursuant to the requirements of § 1340.3-3(d)(5), unless the written consent of the agency providing the information and the individual to whom the information applies or his representative has been obtained. No report or other documentation of a program or project to be disclosed outside the program or project may contain information that might serve to identify any person without his written consent or that of his representative.

Subpart C—Child Abuse and Neglect Grants to States Under the Act and Under Title IV of the Social Security Act

§ 1340.3-1 Purpose and eligible applicants.

(a) States that qualify under § 1340.3-2, may receive grants to initiate or continue the support of programs or projects of the State or one of its political subdivisions which can be expected to assist the State in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs. The Act also requires that the single State agency comply with certain requirements in order to begin or continue the receipt of funds for programs or projects related to child abuse and neglect assisted under Part A or B of Title IV of the Social Security Act.

(b) This subpart describes the process States must follow to establish their compliance and to apply for funds provided under section 4(b)(1) of the Act (Pub. L. 93-247). The process the single State agency must follow to establish compliance under the Act (and under the Social Security Act) is described in 45 CFR Part 220.

§ 1340.3-2 Establishment of compliance.

(a)(1) In order to be eligible for Federal financial assistance for programs or projects related to child abuse and neglect assisted under section 4(b)(1) of this Act, a State shall provide, in such form and with such documentation as the Secretary may require, a statement that the State meets the requirements of the Act and of this part, signed by the Governor. All legal opinions shall be certified by the Attorney General of the State.

(2) In order to be eligible for Federal financial assistance for programs or projects related to child abuse and neglect assisted under Part A or B of Title IV of the Social Security Act, the single State agency shall provide, in such form and with such documentation as the Secretary may require, a statement that it meets the requirements of the Act (Pub. L. 93-247) and the Social Security Act, in accordance with regulations published in 45 CFR Part 220.

(3) For programs or projects funded under section 4(b)(1) of the Act, the requirements are set forth in § 1340.3-3(d) (1)-(10). For programs or projects funded under Part A or B of Title IV of the Social Security Act, the requirements are set forth in 45 CFR 220.

(b) Whichever State office, agency, or organization is designated by the Governor, may apply for financial assistance under section 4(b)(1) for the payment of reasonable and necessary expenses in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs. Such State office, agency, or organization need not be limited in its mandate or activities to child abuse and neglect. Such State office, agency, or organization designated by the Governor may enter into purchase agreements with other offices, agencies, or organizations (including Indian Tribal governments) to conduct activities under the grant. The application for such funds shall include a description of the activities presently conducted by the State and its political subdivisions in relation to preventing and treating child abuse and neglect, the activities to be assisted under the grant, a statement of how the proposed activities are expected to develop, strengthen or carry out child abuse prevention and treatment programs, together with a budget in the form and detail and in accordance with the procedures prescribed by the Secretary, and such additional information in such form and with such documentation as the Secretary may require.

§ 1340.3-3 Qualification for assistance.

(a) The Act enumerates ten elements of a comprehensive system to prevent and treat child abuse and neglect which a State must have in order to qualify for assistance under section 4(b)(1). The enactment of identical laws and procedures in the States is not necessary. Rather, as its purpose, the Act seeks to insure that all States receiving assistance under this subsection (in meeting the ten requirements) must provide what may be grouped into four fundamental child protective capabilities: (1) Detection through third party reporting of children in danger, including mandatory and permissive reporting of suspected child abuse and neglect; (2) child protective services to provide non-criminal investigations for the verification of reports, to provide immediate protection of children through such means as protective custody, and to provide rehabilitative and ameliorative services; (3) juvenile or family court action to remove a child or to impose treatment services; and (4) law enforcement investigations and criminal court prosecution, when appropriate.

(b) Similarly, it is not necessary for States to adopt language for the definition of "child abuse and neglect" identical to that used in the Act. A State definition which is the same in substance as the one set forth in this part will be sufficient. In addition, nothing in this part is intended to prevent a State from further elaborating on the definition or from providing additional grounds to consider a child abused or neglected. This part takes this approach in recognition of the need to allow and encourage flexibility and innovation in light of the diverse local conditions found from State to State and community to community.

(c) Finally, in order to facilitate compliance, this part makes a distinction between requirements that can be satisfied by a specific State law and those that can be satisfied by a legally authorized and legally binding administrative procedure, if certified by the State's Attorney General.

(d) In order for a State to qualify for assistance under section 4(b)(1) of the Act, the State shall satisfy each of the following ten requirements:

(1) The State must have in effect a child abuse and neglect law which includes provisions for immunity for all persons reporting, whether mandated by law or not, instances of known or reasonably suspected child abuse and neglect, from civil or criminal prosecution under any State or local law, arising out of such reporting. In the absence of a specific statutory provision in an existing child abuse and neglect reporting law, this requirement may be satisfied, but only until July 1, 1975, or the close of the next session of the State legislature, whichever is later, by a legal opinion of the State's Attorney General holding that such immunity exists under State law.

(2)(i) The State must provide for the reporting of known or suspected instances of child abuse and neglect. This requirement shall be deemed satisfied if a State requires specified persons by law, and has a law or administrative procedure which requires, allows, or encourages all other citizens, to report known or suspected instances of child abuse and neglect to one or more properly constituted authorities with the power and responsibility to perform an investigation and take necessary ameliorative and protective steps as required in paragraph (d)(3) of this section. A properly constituted authority may include the police, the juvenile court or any agency thereof, or a legally mandated, public or private child protective agency: *Provided*. However, that a properly constituted authority must be an agency other than the agency, institution or facility involved in the acts or omissions, if the report of child abuse and neglect involves the acts or omissions of a public or private agency or other institution or facility.

(ii) In the absence of a specific statute, the requirements of this subsection may be satisfied by an opinion of the State Attorney General holding that the State administrative procedures in this regard are legally binding.

(3)(i) A State must provide that upon the receipt of a report of known or suspected instance of child abuse or neglect an appropriate investigation by a properly constituted authority shall be initiated promptly to substantiate the accuracy of the report. Such investigation may include contact with central registers, field investigations and interviews, home visits, consultation with other agencies, medical examinations, and psychological and social evaluations.

(ii) The State must provide further that, upon a finding of abuse or neglect, immediate steps, as required by law and/or administrative procedure, shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect. Such steps may include multidisciplinary teams, instruction in education for parenthood, protective and preventive social counselling, foster care, emergency caretaker service, emergency homemaker service, emergency shelter care, emergency medical service, and, if appropriate, criminal court or juvenile court action, in order to protect the child and help strengthen the family, help the parents in their child rearing responsibilities, and if necessary, remove the child from a dangerous situation.

(4) The State must demonstrate that there are in effect throughout the State, in connection with the enforcement of child abuse and neglect laws and with the reporting of suspected instances of child abuse and neglect, such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State has operational procedures and capabilities sufficient to deal effectively with child abuse and neglect cases in the State. Such operational procedures and capabilities shall include: provision for receipt, investigation and verification of reports; provision for the determination of treatment or ameliorative social service and medical needs; provision of such services; and, when necessary, resort to criminal or juvenile court.

(5) The State must provide for methods to preserve the confidentiality of all records concerning reports of child abuse and neglect in order to protect the rights of the child, his parents or guardians. This section shall be satisfied only if a State has a law which makes such records confidential and which makes any person who permits or encourages the unauthorized dissemination of their contents guilty of a crime. Such law may allow access to such records but only to the following agencies and persons: (i) A legally mandated, public or private child protective agency investigating a report of known or suspected child abuse or neglect or treating a child or family which is the subject of a report or record; (ii) a police or other law enforcement agency investigating a report of known or suspected child abuse or neglect; (iii) a physician who has before him a child whom he reasonably suspects may be abused or neglected; (iv) a person legally authorized to place a child in protective custody when such person has before him a child whom he reasonably suspects may be abused or neglected and such person requires the information in the report or record in order to determine whether to place the child in protective custody; (v) an agency having the legal responsibility or authorization to care for, treat, or supervise a child who is the subject of a report or record, or a parent, guardian, or other person who is responsible for the child's welfare; (vi) any person named

in the report or record who is alleged to be abused or neglected; if the person named in the report or record is a minor or is otherwise incompetent, his guardian ad litem; (vii) a parent, guardian, or other person responsible for the welfare of a child named in a report or record, with protection for the identity of reporters and other appropriate persons; (viii) a court, upon its finding that access to such records may be necessary for determination of an issue before such court, but such access shall be limited to in camera inspection, unless the court determines that public disclosure of the information contained therein is necessary for the resolution of an issue then pending before it; (ix) a grand jury upon its determination that access to such records is necessary in the conduct of its official business; (x) any appropriate State or local official responsible for the child protective service or legislation carrying out his official functions; (xi) any person engaged in a bona fide research purpose, provided, however, that no information identifying the subjects of the report shall be made available to the researcher unless it is absolutely essential to the research purpose and the appropriate State official gives prior approval. Nothing in these regulations is intended to affect a State's laws or procedures concerning the confidentiality of its criminal court and its criminal justice system.

(6) The State must provide for the cooperation of law enforcement officials, courts of competent jurisdiction, and all appropriate State agencies providing human services in relation to preventing, identifying and treating child abuse and neglect. Such cooperation may include joint consultation and services, joint planning, joint case management, joint public education and information service, utilization of each other's facilities, and joint staff and other training.

(7) The State must provide that in every case involving an abused or neglected child which results in a judicial proceeding, a guardian ad litem shall be appointed to represent the child in such proceedings. The requirement of this clause may be satisfied by a State law or by a legal opinion of the State's Attorney General holding that such appointments can be made, and by a statement from the Governor that such appointments are made, in all cases. Such guardian ad litem need not be an attorney; however, such representative may be an attorney charged with the presentation in a judicial proceeding of the evidence alleged to amount to the abuse and neglect, so long as his legal responsibility includes representing the rights, interests, welfare, and well-being of the child; where such appointments are made, the legal opinion of the State Attorney General must specify that such attorney has said legal responsibility.

(8) The State must provide that the aggregate of State support for programs or projects related to child abuse and neglect assisted by State funds shall not be reduced below the level provided during Federal fiscal year 1973 and set forth policies and procedures designed to assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of State funds which would, in the absence of Federal funds, be available for such programs and projects.

(9) The State must provide for dissemination of information to the general public with respect to the problem of child abuse and neglect and the facilities and the prevention and treatment methods available to combat instances of child abuse and neglect; and

(10) To the extent feasible, the State must insure that parental organizations combating child abuse and neglect, as recognized by the State, receive preferential treatment.

§ 1340.3-4 Approval of compliance statements and plan amendments.

(a) The Secretary shall approve a compliance statement submitted under this subpart if he finds that it meets the requirements of this subpart and of the Act.

(b) If a State does not appear to meet the requirements of this subpart, the State will be provided reasonable opportunity to qualify before final action on the application or continued extension of funds is taken by the Secretary.

(c) The requirement that a single State agency must comply with section 4(b)(3) of the Act and 45 CFR Part 220 in order to continue receiving funds for programs or projects related to child abuse and neglect assisted under Part A or B of Title IV of the Social Security Act shall take effect on July 1, 1975, or the close of the State's next legislative session, whichever is later.

§ 1340.3-5 Approval of applications, plan amendments, and funds.

(a) The Secretary shall approve an application for funds under section 4(b)(1) of the Act if he finds: (1) That the State applying for such funds qualifies for such funds under section 4(b)(2) of the Act, (2) that the funds are intended to be used to develop, strengthen, or carry out child abuse or neglect prevention or treatment programs, (3) that the State is otherwise in compliance with these regulations, and (4) that the funds requested are within the State's allocation as determined pursuant to § 1340.3-7.

(b) The Secretary shall approve the initial or continued use of funds for the single State agency's programs or projects related to child abuse and neglect assisted under Part A or B of Title IV of the Social Security Act if he finds that the single State agency qualifies for such funds under the Act (Pub. L. 93-247) and under the Social Security Act, in accordance with the regulations published in 45 CFR Part 220.

§ 1340.3-6 Funds available.

Not less than 5 per centum and not more than 20 per centum of the sums appropriated under the Act shall be used by the Secretary for making grants to the States under subsection 4(b)(1) of the Act.

§ 1340.3-7 Allocation of funds available.

(a) Funds available for grants to States for a fiscal year under section 4(b)(1) of the Act shall be allocated among the States on the basis of the following criteria:

(1) An amount of $20,000, or such other amount as the Secretary may determine, for a fiscal year, plus,

(2) An additional amount bearing the same ratio to the total amount made available for this purpose (after providing for the minimum amounts in paragraph (a)(1) of this section as the number of children under the age of eighteen in each State bears to the total number of children under eighteen in all the States. The number of children under the age of eighteen to be used in this allocation shall be the number as determined by official estimates furnished to the Secretary by the Department of Commerce by October 1 of the fiscal year for which Federal grant funds are appropriated.

(b) The Director will announce the allocations available to the States under section 4(b)(1) of the Act and this subpart.

§ 1340.3-8 Reallocation of funds available.

If a State has not qualified for assistance under section 4(b)(1) of the Act prior to the date designated by the Secretary in each fiscal year, the amount previously allocated to that State under § 1340.3-7 shall be used by the National Center on Child Abuse and Neglect for such purposes under the Act as the Secretary shall determine.

Subpart D—Coordination of Program Activities

AUTHORITY: Sec. 6(a), 88 Stat. 7 (Sec. 6(a), Pub. L. 93-247); Sec. 7, 88 Stat. 8 (Sec. 7, Pub. L. 93-247).

SOURCE: 41 FR 54763, Dec. 15, 1976, unless otherwise noted.

§ 1340.4-1 Purposes.

(a) There are a number of Federal agencies which expend Federal funds to administer or assist programs and activities related to child abuse and neglect.

(b) The purposes of this subpart are:

(1) To ensure effective coordination among programs and activities related to child abuse and neglect under the Act and other such programs and activities administered and assisted by other Federal agencies, as required by Section 7 of the Act;

(2) To achieve the most effective and efficient utilization of Federal re-

sources in the design, development, implementation and management of programs and activities related to the prevention, identification or treatment of child abuse and neglect;

(3) To ensure that programs and activities are not undertaken in a unilateral manner;

(4) To ensure that programs and activities are not duplicative; and,

(5) To provide that the results, outcomes, or data generated by programs and activities are made known and available to each of the agencies participating.

(c) In order to accomplish these purposes, it is necessary that there be established and maintained an ongoing effort among the participating agencies to clarify their respective roles; identify and centrally maintain information about their respective efforts; establish and maintain appropriate program interaction; and, achieve the maximum feasible level of synchronization of effort.

(d) It is not the purpose of this subpart to alter in any manner the basic responsibility of an agency to administer and manage its programs and activities.

§ 1340.4-2 Definitions.

For purposes of this subpart.

(a) "Advisory Board" means the Advisory Board on Child Abuse and Neglect, established by the Secretary under the Act.

(b) "Executive Secretariat" means the National Center on Child Abuse and Neglect in its performance of the supportive administrative functions of the Advisory Board.

(c) "Assistant Secretary" means the Assistant Secretary for Human Development of the Department of Health, Education, and Welfare.

(d) "Activities" (and in the singular, "activity" as indicated by the context) means programs and activities related to child abuse and neglect administered or assisted by participating agencies, including but not limited to:

(1) Grants in aid;

(2) Grants for research and demonstration projects;

(3) Contracts conduct activities related to child abuse and neglect;

(4) Development of training curricula and supporting educational materials;

(5) Provision of technical assistance;

(6) Provision of services;

(7) Data collection;

(8) Development of program standards;

(9) Development of short and long range plans;

(10) Development of rules, regulations, policies or procedures.

(e) "Participating agencies" means the various Federal agencies with responsibilities for activities related to child abuse and neglect which by virtue of such responsibilities are, or are eligible to be, represented on the Advisory Board.

§ 1340.4-3 Reports and Materials.

Each participating agency shall, as a minimum, provide the following reports and material regarding its activities at the central and regional office levels to the Advisory Board:

(a) An annual written report on long range plans and budget projections;

(b) An annual written report on contemplated activities and budget projections for the succeeding fiscal year with a specific description of what those activities are to achieve and how they relate to existing activities;

(c) An annual written report at the conclusion of each fiscal year on the results and accomplishments of activities conducted during that year and a recapitulation of funds expended;

(d) Interim reports on activities which appear to warrant consideration or some coordinating action by the Advisory Board prior to the submission of annual reports;

(e) Draft copies of statements of work for contracts or grants, for information, review, and coordination;

(f) Final copies of statements of work referred to in paragraph (e) of this section, provided at the time of issuance;

(g) Brief statements of the subject matter, methodology, and objectives of unannounced or solicited activities approved for funding, at the time of award;

(h) Draft regulations or other requirements, guidelines, and standards for activities provided in timely fashion for review and coordination; and,

(i) Final copies of the materials referred to in paragraph (h) of this section, at the time of issuance.

§ 1340.4-4 Coordination Process.

(a) The Advisory Board shall be informed of all the planned activities reported to it pursuant to § 1340.4-3, in the context of the total Federal effort at both central and regional office levels.

(b) If the Advisory Board finds that the planned activities appear to represent an inappropriate duplication or overlap of efforts with another participating agency or that more effective coordination can be achieved, the Advisory Board, through Assistant Secretary for Human Development, shall bring such matter and its recommendations to the attention of the agencies involved. Those agencies shall expeditiously develop and report to the Advisory Board how they propose to coordinate their activities as well as a timetable for the actions proposed. In the event that there is an urgency for the rapid resolution of the problem, the Board shall set a deadline for the resolution of the problem.

(c) The Board shall report to the Secretary on a regular basis if there are inappropriate duplications or overlap of efforts in planned activities.

(d) Participating agencies shall encourage their regional office representatives to undertake joint planning and coordination of activities in their regions within the framework of national coordination under the Advisory Board, through such means as interagency committees and agreements.

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